CLAIMS AUDIT GUIDELINES

INTRODUCTION

A. BACKGROUND

Claims processing services are competitively procured through contractors. Each TRICARE claims processing contractor is contractually responsible for timely and accurate adjudication of all TRICARE claim types for a specific regional jurisdiction. Each contractor is also responsible for reporting to TMA payment records of all claim transactions via an electronic teleprocessing network. These payment records are essential to both the accounting and statistical requirements of TMA in management of the Program and in required reports to the Department of Defense, Congress, other governmental entities and to the public.

B. PURPOSE OF THE CLAIMS AUDIT

The purpose of the ongoing claims audit program of TMA is to determine the accuracy of each contractor's claims processing and payment record coding. The error findings are reported in terms of payment error rates and payment record occurrence error rates. These error rates are important indicators of each contractor's performance. The error rates are used to determine whether the contractor qualifies for monetary awards or reductions in accordance with the positive and negative provisions of the contracts. The audits also serve to identify specific areas of contractual noncompliance requiring corrective action by the contractor and to determine if certain changes to operational and policy requirements have been implemented by each contractor as directed by TMA.

C. APPLICABILITY OF THE CLAIMS AUDIT GUIDELINES

These procedures and guidelines are intended solely for the use of the auditors in the TMA, Claims Operations Office or the Claims Review Assistance Services contractor. They have been written solely for the purpose of facilitating the auditing of contractor processed claims. They are not intended, nor should they be construed, in any way to take precedence over or contradict contractor contractual requirements or existing legislative, regulatory or policy directives relative to Chapter 55, Title 10, United States code. They are not intended to provide operational or procedural guidance to the contractor.

Any contradictions or inconsistencies between these guidelines and the directives and contractual requirements referred to above are unintentional and are to be brought to the attention of the Chief, Claims Operations Office, TMA.

CLAIMS AUDIT GUIDELINES

TABLE OF CONTENTS

CLAIMS AUDIT GUIDELINES

CHAPTER 1 - CLAIMS AUDIT PROCESS

TABLE OF CONTENTS

CLAIMS AUDIT GUIDELINES

CHAPTER 1 - CLAIMS AUDIT PROCESS

A. General

1. Purpose. The primary purpose of the TMA claims audit is to determine the accuracy of institutional claims payments, non-institutional claims payments, and institutional and non-institutional payment record coding. The resulting error rates are used in the evaluation of contractor performance and in the quarterly application of incentive provisions of contracts.

2. Scope. The audit process entails 1) the evaluation of contractor payment determinations based on the claims, attendant documentation and other source documents and files used in the adjudication process and 2) the evaluation of contractor payment record coding based on the above documentation and the contractor payment determinations. These evaluations are made by comparing the contractor's processing and coding decisions with requirements in the TRICARE Policy Manual; the TRICARE Reimbursement Manual; the Managed Care Support Contract Operations Manual; the TRICARE/CHAMPUS Automated Data Processing and Reporting Manual; and the individual contracts.

3. Claim Sampling. Generally, each contract is audited on a quarterly basis. Samples of each contractor's processed claims are selected by contract from edited payment record submissions received at TMA within each calendar quarter. This sample selection process is automated and begins the sequence of auditing events.

B. Conducting the Audit

1. Preparation

a. Prior to beginning each audit, the auditor will review the Deficiency File for the individual contract he/she is to audit to become familiar with error findings from previous audits.

b. The claims and corresponding HADRs are to be sequentially numbered for ease in associating these.

2. Use of the HCSR Audit Detail Report (HADR)

a. The primary tool during the audit is the HADR. This report is a facsimile of the payment records as reported by the contractor for those claims selected for audit. The HADR format is found in the TMA Automated Data Processing and Reporting Manual, Chapter 2. Each data field is identified by abbreviated name and labeled with an alpha-numeric code which is used for recording error conditions. The auditor records errors on this form as they are identified by highlighting or otherwise marking the error code or field. Explanations of reasons for assessing errors will also be entered on the HADR in narrative form.

Since these reports will be stored after the audit, care must be taken to maintain their legibility.

b. The HADR also contains provider information, procedure and diagnostic code narrative descriptions, pricing information, and zip code catchment area information based on the data submitted on the payment record by the contractor to facilitate recording of errors and eliminate some file look-ups.

3. Auditing Techniques. Specific error assessment and auditing guidelines are provided in Chapters 3, 4, and 5. Each auditor develops an approach to verify the accuracy of each contractors payment record coding and benefit determinations during on-the-job training and experience. Generally, the following considerations apply to every claim audited. These are not all-inclusive nor is any sequential order prescribed. Each auditor is expected to develop an approach which is most effective for timely and accurate results.

a. Was the claim properly executed (appropriate signatures, timely filed, valid claim form, provider participation certification)?

b. Is the patient eligible? Is the patient enrolled in TRICARE Prime? Is the patient and sponsor information properly coded?

c. Is the provider authorized? Is the provider contracted or not contracted? Is the provider information (provider number, zip code, specialty, capacity) coded correctly?

d. Is the diagnosis coded properly? Is it covered?

e. Is a preauthorization or Nonavailability Statement needed? If so, is it present?

f. Are the service(s) and date(s) of service coded properly? Is each service a benefit? Is each service medically necessary? Was it provided at the appropriate level? Does it require medical review? If so, is documentation of the medical review determination present and correct?

g. Are the billed charges reported correctly? Are the allowed amounts correct? Was other health insurance or third party liability properly considered? Is the deductible properly credited? Is the patient's cost-share correct? Is the amount of payment correct? Was payment made to the correct party?

h. Was the payment record properly prepared? Are the data fields coded correctly?

4. Medical Review Determinations. Claims involving questionable contractor decisions regarding medical necessity and appropriateness of care issues, regardless of the dollar amounts involved, will be handled as follows if available policy guidelines are silent on the issue:

a. Consult with a Nurse Consultant or a registered nurse to make a determination.

b. Based on consultation with the above individuals, a determination regarding the contractor's decision will be made for purposes of issuing the audit report timely.

CLAIMS AUDIT GUIDELINES

C. Post-Audit Reports

1. Creating the Post-Audit Reports. After all claims for the audit month have been audited, the auditor enters the error findings and comments into the automated HCSR Audit System and generates the post-audit reports. The post-audit reports consist of the following:

a. Contractor HCSR Audit Summary Report

b. HCSR Audit Analysis of Errors Report

c. HCSR Audit Listing, Part I and II

d. HCSR Audit Error Report

2. Verification of the Audit Reports. Since the accuracy of the quarterly claims audit reports is essential, the following steps are critical.

a. Auditors are to verify that the totals on the Audit Summary Report match the totals on the Claim Summary Report. Inconsistencies which the auditor is unable to resolve are to be reported to the lead or supervisor.

b. Auditors will also compare the data reported on the Audit Errors Report with the highlighted errors contained on the HADR.

D. Analysis of Contractors Errors

1. An Analysis of Errors Summary is prepared for each audit by the auditor following the completion of the second rebuttal.

2. Significant Audit Findings. Occurrence and payment error findings are considered significant deficiencies when they represent high volume errors, high dollar amount errors, or errors which by their nature have the potential for rarely occurring. Also significant are those findings which indicate a contractor has failed to implement or has incorrectly implemented a contractual requirement, e.g., Policy/Reimbursement/Operations/ADP Manual change, or which indicate other substantive processing problems, e.g., EOBs sent to minors.

3. Monitoring Deficiencies. Prior to beginning an audit, the auditors will review each contractor's error report file for those findings to be monitored.

E. Rebuttals of Audit Findings

1. Time Period. Generally contractors have 45 calendar days following receipt of the audit reports to rebut the findings or notify TMA/COO or designee, that no rebuttal will be submitted.

2. Responses to Rebuttals

CLAIMS AUDIT GUIDELINES

a. Responses must be clear, concise and self-explanatory, addressing each issue raised by the contractor. In most cases, it will be necessary to reiterate the issue or question in order that those reviewing and concurring in the reply will fully understand the response. This is especially important in those cases where the auditor is sustaining the original determination or removing errors for reasons other that those cited in the contractor's rebuttal. Appropriate references, e.g., Operations Manual or ADP Manual are to be cited whenever possible.

b. Responses are to be in a format which addresses the claim number, beneficiary name, claim type, disputed errors, contractor rebuttal position, position after consideration, errors removed and errors assessed.

F. Confidentiality of Audit Documents. All TRICARE claims and claim documentation used in the claims audit are subject to the provisions of the Privacy Act of 1974, the HIPAA Privacy Rule of 2002, and all DOD Privacy requirements since they contain information of a personal nature on each beneficiary. Due to the confidential nature of the information, each auditor is responsible for safeguarding these documents as follows:

1. While auditors are away from their work area for any extended time, such as leave or after duty hours, all claims are to be placed in the file drawers.

2. For a brief period of absence, such as a break, lunch or meeting, all documents are to be covered or placed in such a way so that they are not visible to a casual observer.

CLAIMS AUDIT GUIDELINES

CHAPTER 2 - AUTOMATED AUDIT SYSTEMS

TABLE OF CONTENTS

CLAIMS AUDIT GUIDELINES

CHAPTER 2 - AUTOMATED AUDIT SYSTEMS

A. Introduction. This chapter describes the objectives and features of the automated HCSR Audit System and provides an overview of the auditor's interface with this system. The objectives of the HCSR Audit System is to facilitate and enhance the accuracy and timely completion of the audits and production of audit reports through automation of the claims audit functions.

On-line access to procedure codes, zip code tables, provider information, pricing information, deductible and catastrophic cap information.

Error collection

Production of audit reports

Audit error summary reports

B. Scope of Automated Features.

1. The HCSR Audit System interfaces with the Care Information (CI) system (HCSR) to make a quarterly random selection of claims. During this selection process, the system also interfaces with various files and tables to provide narrative descriptions of procedure and diagnosis codes, catchment area information based on zip codes, provider information, and pricing data.

2. Selected claim and error data is collected and maintained on the HCSR Audit databases. These databases are then used to produce claims sampling and detail reports used by the auditors to audit each claim. After the claims have been audited, the system provides for automated collection of errors through on-line entry of payment and coding errors by the auditor to the claim audit database. The quarterly audit cycle is concluded with automated generation of final audit reports and, subsequently, rebuttal reports from claim and error data maintained on the audit databases. The audit databases retain claim and error data for each audit cycle for the current and previous quarters. This historical data allows for future creation of special post-audit reports for trend analysis and summary reporting.

C. Description of Automated Functions. The automated function is designed to interface directly with the audit database to provide required data. A brief narrative description of the functions follows:

1. Select Claim Sample. The system is designed to provide an automated capability for selecting a random sample of claims to be audited. The claims are selected from edited submissions that pass the edit levels at TMA each quarter.

2. Access Tables. Tables maintained in the audit database are available on-line during the processing of claim sampling reports.

a. Two tables maintained on the audit database are available for online access and updating. They are:

(1) Error Code Table - A table containing audit error codes.

(2) Auditor ID Table - A table used to identify individuals
having authorized access to the automated systems.

b. Other tables used by the system are available for online access by the auditors. These tables are maintained and updated by either TMA or the input tapes from the contractor. They are:

(1) Procedure Information

(2) Pricing Information

(3) Catchment Area Zip Codes

(4) Provider Information

(5) Catastrophic Cap and Deductible Information

3. Create Claim Sampling Reports (pre-audit reports). This process creates reports based on claims selected for each contract each audit quarter. They are:

a. HCSR Audit Detail Report (HADR). Report #HA200-001 are produced for each claim selected for audit. These reports contain detail claim data to be audited, all error codes with narrative definition that were identified by the claim audit system edits, table information extracted for the detail claim data, and the auditor error code applicable for each element in the claim.

b. HCSR ICN Listing Report. Report #HA160-001 contains claim numbers for all claims selected for audit within a contract for the audit period. These reports are used to request the hard copy claims and supporting documentation from the contractor.

4. Enter Audit Errors. This is a process of entering audit errors, payment error amounts, or auditor comments to the claim audit database either during or upon completion of the audit of the hardcopy claims and payment records.

5. Create Final Audit Reports (post-audit reports). After all claims have been audited and audit errors have been entered into the HCSR Audit System, an auditor may request creation of a final audit report or a rebuttal report. Final reports are then produced for the specified contract number and audit period from the data maintained on the claim audit database. The final reports are:

a. Contractor HCSR Audit Summary Report. Report #HA280-001 provides the total number of errors for each claim type, total dollar amounts of payment errors and error rates.

b. HCSR Audit Analysis of Errors Report. Report #HA260-001 provides the number of errors assessed for each error type and category.

c. HCSR Audit Listing, Part I and II Report. Report #HA240-001 provides a summary listing of payment and occurrence errors by ICN number.

d. HCSR Audit Error Report. Report #HA220-001 provides a report of all errors assessed by claim number and the auditor's comments (if any). This report is not produced when rebuttal reports are generated.

6. Maintain History Data. The audit database is updated with each sample selection and as each audit is entered. The database contains audit data for the current quarter and previous quarters for each contract. This allows for recovery of audit data for any audit period maintained in the history files.

CLAIMS AUDIT GUIDELINES

CHAPTER 3 - AUDITING SPECIAL CLAIM CONDITIONS

TABLE OF CONTENTS

EXHIBITS

CLAIMS AUDIT GUIDELINES

TABLE OF CONTENTS

CLAIMS AUDIT GUIDELINES

CHAPTER 3 - AUDITING SPECIAL CLAIMS CONDITIONS

CATASTROPHIC LOSS PROTECTION

For TRICARE Standard cost-share and deductible amounts are applied toward the catastrophic cap as the claims are processed for each fiscal year. For TRICARE Prime and TRICARE Extra claims, all beneficiary cost-share and deductibles specified in the contract shall be applied toward the cap, including nominal copayments for outpatient care.

CLAIM FORM - LASER PRINTED

Laser printed claim forms are only acceptable from participating providers who have filed a certification with the appropriate contractor that he/she will fully comply with the certification's terms and conditions of the TRICARE participation agreement. These types of forms are not acceptable, if the claim is from a nonparticipating provider. Laser printed forms are difficult for the contractors to distinguish and even more difficult for auditors since claims for audit are usually photocopies. Reference: MCSC Operations Manual, Chapter 8, Section 1, 3.3

COMBINING IDENTICAL PROCEDURES ON A SINGLE PAYMENT RECORD DETAIL LINE

Combining charges for the same procedures having the same billed charges for health care service records, is optional with the contractor if the same action is taken with all. The option to combine like services shall be applied to those services rendered in the same calendar month. Any denied charges would have to be detailed into a separate line from those being allowed for payment. Reference: MCSC Operations Manual, Chapter 8, Section 8, 3.0.

COST-SHARE - ACTIVE DUTY INPATIENT

The per diem cost-share rate for active duty dependents' inpatient hospital claims changes yearly. See TRICARE Reimbursement Manual, Chapter 2, Section 1, for rates and effective dates.

DEFINITIONS - TMA

TMA definitions are contained in MSCS Operations Manual, Appendices, Appendix A.

DEVELOPMENT DOCUMENTATION

MCSC Operations Manual, Chapter 8, Section 7, requires contractors to document development actions on the face of the claim or on attachments to the claim. Indicator codes in the history file or other electronic file are acceptable for audit purposes.

DOCUMENTATION OF MEDICAL REVIEW

MCSC Operations Manual, Chapter 7, Section 1, 2.0, requires different levels of medical reviews that must be documented. A stamp on the claim or other such indicator that a claim was routed to a "medical review" unit does not

provide sufficient evidence that the claim was subjected to review. Supporting documentation of the reviewer's determination and rationale for approval or denial of coverage is required. However, the lack of such documentation is not necessarily an indication that a claim was incorrectly processed if there is other documentation with the claim that supports the pay/denial action. Errors are to be assessed if 1) prepayment medical review of the particular claim is a specific requirement in the MCSC Operations Manual or TRICARE Policy Manual and 2) the documentation with the claim is not sufficient to support the contractor's processing action.

DOUBLE COVERAGE - ASSISTANCE PROGRAMS

The law requires TRICARE to be secondary payer to everything but Medicaid. Unless a plan or program is specifically mentioned as an exception, TRICARE is secondary. Since no specific instructions have been issued regarding claims involving coverage by such assistance programs as the United Way, Easter Seal, Muscular Dystrophy, Crippled Children's Society, etc., TRICARE is to be considered secondary payer in these instances. Reference: TRICARE Reimbursement Manual.

DOUBLE COVERAGE VS NONAVAILABILITY STATEMENTS

A Nonavailability Statement is not required if the other insurance is primary payer, regardless of the coverage determinations on specific line items or the actual amounts paid by the other insurance.

DOUBLE COVERAGE - NON-DEVELOPMENT PAYMENT ERRORS

Auditors are to follow these guidelines in determining whether to assess errors on claims paid as TRICARE primary when the contractor does not submit documentation verifying that no double coverage exists:

1. No payment error will be assessed when:

a. The claim form contains no information regarding other coverage or
contains a negative indication; and

b. The contractor’s claim history file indicates no other coverage within the twelve months preceding the earliest date of service; and

c. There is no information with the claim to suggest that the charges have
been submitted to, or paid by, other insurance.

2. Payment errors will be assessed when:

a. The claim form indicates other coverage which appears to be primary,
regardless of what is contained in the claims history file or

b. The claim history file contains evidence of other insurance coverage within 12 months preceding the earliest date of service, even though the claim does not indicate such coverage.

CLAIMS AUDIT GUIDELINES

The above guidelines in no way negate the MCSC Operations Manual requirement that, when double coverage is known, claims are to be accompanied by evidence of processing by the double coverage plan, i.e., a copy of an EOB from the other plan, evidence from the other plan that the services are not covered or an entry on the claim form made by the provider of the amount paid by the double coverage plan.

DOUBLE COVERAGE - SUPPLEMENTAL INSURANCE PLANS

In order to be considered supplemental coverage the plan must state that its benefits are payable only after a claim has been adjudicated by the primary coverage. Supplemental insurance plans are not considered double coverage. Income maintenance plans are also not considered double coverage. For more information reference TRICARE Reimbursement Manual, Chapter 4.

DRG - COORDINATION OF BENEFITS

Reference the TRICARE Reimbursement Manual, Chapter 4, Section 4.

DRG - DISCOUNT AGREEMENTS

Reference the TRICARE Reimbursements Manual, Chapter 3, Section 3.

DURABLE MEDICAL EQUIPMENT - PFPWD PRORATED

TRICARE Policy Manual Chapter 8, outlines steps contractors are to take to process DME claims under PFPWD. The authorization allows a 90-day period during which the purchase of the DME must be made or else another authorization is required. The requirement for the authorization and its restriction to a 90-day period assures that the benefit is being extended for necessary equipment which is acquired at the time the need exists. The 90-day authorization period does not restrict the coverage of the DME to this time frame nor does it dictate the cost-sharing period.

FORMER SPOUSES

The TRICARE Policy Manual, lists conditions under which a former husband or wife of a member or former member is eligible for TRICARE.

NONAVAILABILITY STATEMENTS - ANCILLARY CLAIMS

Contractors need not return inpatient ancillary claims for a copy of the Nonavailability Statement if through reasonable efforts, a contractor can determine that the unprocessed claim is directly related to a NAS indicator on DEERS. Ancillary claims not having any of the documentation noted above or with no annotation will be counted as payment errors.

NUMBER OF SERVICES - PHYSICIAN DISPENSED DRUGS

The number of services for physician dispensed drugs is "one" for all drugs dispensed during a single visit. If a drug or drugs were dispensed at multiple visits, the number of services is equal to the number of visits during which drugs were dispensed.

PARTICIPATION AGREEMENT

CLAIMS AUDIT GUIDELINES

Each claim completed by a non-network provider should show the provider's intentions regarding his or her TRICARE participation, i.e., acceptance of the TRICARE-determined allowable charge as payment for beneficiary's bill. If no intention is indicated, the claim may be processed as non-assigned or developed for the provider's intention to participate. A general assignment of benefits submitted with a claim is not acceptable documentation of a provider's intention to participate. If a provider representative of an institution that is Medicare participating, or subject to the RTC per diem payment system or the mental health per diem payment system, has properly signed the UB-92, or the HCFA 1500 block 1, but the Form Locator 53 has not been checked, the contractor can still process the claim as participating and need not develop it. Reference: Operations Manual, Chapter 8, Section 7.2.3.

PAYEE - NONPARTICIPATING CLAIMS

Generally, payments on nonparticipating claims or claims qualifying for a split payment are made to the individual signing the claim, the patient, or the sponsor. In the absence of specific TMA policy, no errors will be assessed if payment is made to the beneficiary (either parent or guardian of a minor beneficiary) or sponsor regardless of who signs the claim. (Issues involving the custody of minors or absence of a sponsor from the home are not relevant for determining payee and are generally considered to be domestic matters.) Payments made to beneficiaries under 18 years of age will be considered errors unless the claim contains services for a confidential diagnosis or the beneficiary is a spouse of a sponsor. Payments made to deceased beneficiaries or to the sponsor, spouse, or next-of-kin of a deceased beneficiary without documentation that the payee is the legal representative of the estate will be considered payment errors.

PAY GRADES

Exhibit 1 of this chapter lists comparable ranks for the Armed Forces and their abbreviations.

SIGNATURE - BENEFICIARY

Every claim must bear the signature of the patient or other authorized person to verify that services were rendered and the Government has a legal liability to pay. With some exceptions, unsigned claims must be returned under control for an authorized signature. Reference MCSC Operations Manual, Chapter 8, Section 5.

SIGNATURE - DECEASED BENEFICIARY

If the beneficiary is deceased, the claim must be signed by the legal representative of the estate. If there is no estate (and thus no legal representative), the claim may be signed by sponsor, spouse, or next of kin. For the signature of these individuals to be acceptable, a statement must be submitted that no legal representative has been appointed. Payment errors will be assessed if the necessary documentation is not included with the claim for audit. Reference: MCSC Operations Manual, Chapter 8. Section 5.5.0.

SIGNATURE - PROVIDER

CLAIMS AUDIT GUIDELINES

On all non-network participating claims and on nonparticipating claims which contain itemization of services on the form in lieu of a separate provider billing, the provider's signature or an acceptable facsimile must be entered. Reference MCSC Operations Manual, Chapter 8, Section 5.9.0.

CLAIMS AUDIT GUIDELINES

ARMED FORCES RANKS AND ABBREVIATIONS

EXHIBIT 1

PAY GRADE	RANK ABBREV	RANK	TITLE FOR SALUTATION
		ARMY	
0-10	GEN	General	General
0-9	LTG	Lieutenant General	General
0-8	MG	Major General	General
0-7	BG	Brigadier General	General
0-6	COL	Colonel	Colonel
0-5	LTC	Lieutenant Colonel	Colonel
0-4	MAJ	Major	Major
0-3	CAP	Captain	Captain
0-2	1LT	First Lieutenant	Lieutenant
0-1	2LT	Second Lieutenant	Lieutenant
W-4	CW4	Chief Warrant Officer	Mr. Miss Mrs.
W-3	CW3	Chief Warrant Officer	Mr. Miss Mrs.
W-2	CW2	Chief Warrant Officer	Mr. Miss Mrs.
W-1	WO1	Warrant Officer	Mr. Miss Mrs.
E-9	CSM	Command Sergeant Major	Sergeant Major
E-9	SGM	Sergeant Major	Sergeant Major
E-8	1SG	First Sergeant	First Sergeant
E-8	MSG	Master Sergeant	Sergeant
E-7	SFC	Sergeant First Class	Sergeant
E-7	SFC	Platoon Sergeant	Sergeant
E-6	SSG	Staff Sergeant	Sergeant
E-5	SGT	Sergeant	Sergeant
E-4	CPL	Corporal	Corporal
E-4	SP4	Specialist 4	Specialist
E-3	PFC	Private First Class	Private
E-2	PVT	Private	Private
E-1	PVT	Private	Private
		AIR FORCE	
0-10	GEN	General	General
0-9	LtGen	Lieutenant General	General
0-8	MajGen	Major General	General
		AIR FORCE cont.	
0-7	BrigGen	Brigadier General	General
0-6	Col	Colonel	Colonel
0-5	LtCol	Lieutenant Colonel	Colonel
0-4	Maj	Major	Major
0-3	Capt	Captain	Captain
0-2	1LT	First Lieutenant	Lieutenant
0-1	2LT	Second Lieutenant	Lieutenant

CLAIMS AUDIT GUIDELINES

ARMED FORCES RANKS AND ABBREVIATIONS

EXHIBIT 1

PAY GRADE	RANK ABBREV	RANK	TITLE FOR SALUTATION
W-4	CW4	Chief Warrant Officer	Mr. Miss Mrs.
W-3	CW3	Chief Warrant Officer	Mr. Miss Mrs.
W-2	CW2	Chief Warrant Officer	Mr. Miss Mrs.
W-1	WO1	Warrant Officer	Mr. Miss Mrs.
E-9	CSMgt	Chief Master Sergeant	Sergeant
E-8	SMSgt	Senior Master Sergeant	Sergeant
E-7	MSgt	Master Sergeant	Sergeant
E-6	TSgt	Technical Sergeant	Sergeant
E-5	SSgt	Staff Sergeant	Sergeant
E-4	Sgt	Sergeant	Specialist
	SrA	Senior Airman	Airman
E-3	PFC	Airman First Class	Airman
E-2	PVT	Airman	Airman
E-1	PVT	Airman Basic	Airman

MARINE CORPS

0-10	GEN	General	General
0-9	LTG	Lieutenant General	General
0-8	MG	Major General	General
0-7	BG	Brigadier General	General
0-6	COL	Colonel	Colonel
0-5	LTC	Lieutenant Colonel	Colonel
0-4	MAJ	Major	Major
0-3	CAP	Captain	Captain
0-2	1LT	First Lieutenant	Lieutenant
0-1	2LT	Second Lieutenant	Lieutenant

MARINE CORPS cont.

W-4	CW4	Chief Warrant Officer	Mr. Miss Mrs.
W-3	CW3	Chief Warrant Officer	Mr. Miss Mrs.
W-2	CW2	Chief Warrant Officer	Mr. Miss Mrs.
W-1	WO1	Warrant Officer	Mr. Miss Mrs.
E-9	SgtMaj	Sergeant Major	Sergeant Major
E-9	MGysgt	Master Gunnery Sergeant	Master Gunnery Sergeant
E-8	1st Sgt	First Sergeant	First Sergeant
E-8	Msgt	Master Sergeant	Master Sergeant
E-7	GySgt	Gunnery Sergeant	Gunnery Sergeant
E-6	SSgt	Staff Sergeant	Staff Sergeant
E-5	Sgt	Sergeant	Sergeant
E-4	Cpl	Corporal	Corporal
E-3	LCpl	Lance Corporal	Corporal
E-2	PFC	Private First Class	Private
E-1	PVT	Private	Private

CLAIMS AUDIT GUIDELINES

ARMED FORCES RANKS AND ABBREVIATIONS

EXHIBIT 1

PAY GRADE	RANK ABBREV	RANK	TITLE FOR SALUTATION
		NAVY AND COAST GUARD	
0-10	ADM	Admiral	Admiral
0-9	VADM	Vice Admiral	Admiral
0-8	RADM	Rear Admiral	Admiral
0-7	RADM	Rear Admiral	Admiral
0-6	CAPT	Captain	Captain
0-5	CDR	Commander	Commander
0-4	LCDR	Lieutenant Commander	Commander
0-3	LT	Lieutenant	Lieutenant
0-2	LTJG	Lieutenant Junior Grade	Lieutenant
0-1	ENS	Ensign	Ensign
W-4	CWO-4	Chief Warrant Officer	Chief Warrant Officer
W-3	CWO-3	Chief Warrant Officer	Chief Warrant Officer
W-2	CW-O2	Chief Warrant Officer	Chief Warrant Officer

E-4	E-5	E-6	E-7	E-8	E-9
ABM13	A02	AC1	AOC	BMCS	BMCM
FTM3	AMS2	BM1	BMC	MRCS	BTCM
GMG3	BM2	HT1	AMHC		
BM3	HT2	MS1	PNC		
YN3	SKZ	EM1	AEC		
PN3	CS2	YN1	ATC		
		LNI			

W-1	WO-1	Warrant Officer	Warrant Officer
E-9	MCPO	Master Chief Petty Officer	Master Chief Petty Officer
E-8	SCPO	Senior Chief Petty Officer	Senior Chief Petty Officer
		NAVY AND COAST GUARD cont.	
E-7	CPO	Chief Petty Officer	Chief Petty Officer
E-6	P01	Petty Officer First Class	Petty Officer
E-5	P02	Petty Officer Second Class	Petty Officer
E-4	P03	Petty Officer Third Class	Petty Officer
E-3	SN	Seaman	Seaman
E-2	SA	Seaman Apprentice	Seaman
E-1	SR	Seaman Recruit	Seaman

EXAMPLES OF NAVY & COAST GUARD RATINGS WITHIN PAY GRADES*

CLAIMS AUDIT GUIDELINES

*To convert a rating into the rated into the related pay grade, note the last numeric or alpha character.

CLAIMS AUDIT GUIDELINES

CHAPTER 4 - AUDITING HCSR DATA ELEMENTS

TABLE OF CONTENTS

CLAIMS AUDIT GUIDELINES

CHAPTER 4 - AUDITING HCSR DATA ELEMENTS

TABLE OF CONTENTS

CLAIMS AUDIT GUIDELINES

CHAPTER 4 - AUDITING HCSR DATA ELEMENTS

TABLE OF CONTENTS

CLAIMS AUDIT GUIDELINES

CHAPTER 4 - AUDITING HCSR DATA ELEMENTS

TABLE OF CONTENTS

CLAIMS AUDIT GUIDELINES

CHAPTER 4 - AUDITING HCSR DATA ELEMENTS

This chapter provides special guidance for auditing the data on the Health Care Service Records (HCSR). The names of the fields are arranged in alphabetical order with the corresponding HCSR Audit Detail Report (HADR) audit code following the name of each field. The discussion of payment errors under each data field is intended to provide the auditor with an indication of the types of payment errors that may be related to a particular data field. Chapter 5 provides more information on determining errors, and Exhibit 1 of Chapter 5 lists all the audit codes related to the various data fields and types of errors.

ADMISSION DATE (01D) This is an 8 position numeric field (YYYYMMDD) on the institutional record which is the date the patient was first admitted to the institution for that episode. The admission date is found in UB-92 Form Locator 17. This is required information.

Payment Error: None.

ADMISSION DIAGNOSIS (01E) This is a 6 position alphanumeric field on the institutional record which is the ICD-9-CM code to identify diagnosis under which the patient was admitted to the institution. The code must be the most detailed subcategory or sub-classification and left justified to include leading zeros and blank fill. All zeros are not permitted. The admitting diagnosis can be found in UB-92 Form Locator 76. This is required information.

Payment Error: A payment error may be assessed when the admitting diagnosis does not substantiate an emergency admission and an NAS is required but absent.

AMOUNT ALLOWED (02G) This is a 9 position signed numeric field which includes 2 decimal places. The amount allowed field is used on both the institutional and non-institutional record and is the total amount allowed for all authorized services on the HCSR. If the complete HCSR is denied (Type of Submission "D") this amount must be zero. This is required information unless a unique health care plan allows only partial submission of the financial data.

Payment Error: The following conditions may constitute payment errors:

1. Incorrect determination of allowable charge (prevailing, billed, conversion factor, DRG calculation or per diem) on any service/procedure causing error in total amount allowed.

2. Omission of a billed charge may cause error in allowable amount.

3. Inclusion of extra charges not shown on claim or itemization may cause error in allowable amount.

AMOUNT ALLOWED BY OHI (10G) This is an 9 position signed numeric field including 2 decimal places which is the total amount allowed by other health insurance for all services reported on the HCSR. This is required information.

CLAIMS AUDIT GUIDELINES

Payment Error: See 03G-Amount of Other Health Insurance.

AMOUNT ALLOWED BY PROCEDURE CODE (04I) This is an 9 position signed numeric field including 2 decimal places and is the total amount allowed for the service(s)/supply(ies). This field is applicable only on non-institutional records. The amount allowed is determined based on prevailing rate, conversion amount, billed amount, negotiated rates, or manual pricing. Zeros are to be entered if a claim is denied. This is required information.

Payment Error: The following conditions may represent payment errors:

1. Incorrect determination of allowable charge due to incorrect procedure code, number of services, billed amount, etc.

2. Incorrect pricing methodology used.

AMOUNT APPLIED TOWARD DEDUCTIBLE (06G) This is a 5 position signed numeric field including two decimal places which is that portion of the amount allowed which is applied toward the patient or family deductible. The data is required on the non-institutional record unless a unique health care plan allows only partial submission of the financial data. A value is not required on the institutional record. This is required information.

Payment Error: The following conditions may represent payment errors:

1. Claim or portion of claim not applied to deductible resulting in excess payment. The amount of the excess payment is the payment error amount.

2. Claim or portion of claim applied to deductible in error regardless of whether the claim is paid or denied. The amount of the deductible which is the government's cost-share is the payment error amount.

3. Failure to apply other health insurance payment to deductible. The amount which should be applied to the deductible is the payment error amount.

AMOUNT BILLED (01G) This is an 9 position signed numeric field including 2 decimal places which is the total amount billed for all services reported on the record. The amount billed must be the sum of all total charges per revenue codes on institutional record, or total charge per procedure on non-institutional records. This is required information.

Payment Error: The following conditions may constitute payment errors:

1. Incorrect calculation of total itemized charges.

2. Portion of charges omitted.

3. Inclusion of charges not shown on claim or itemization.

AMOUNT OF OTHER HEALTH INSURANCE (03G) This is an 9 position signed numeric field including 2 decimal places and is the total amount paid by other health insurance for all services reported on the HCSR on both the institutional and

non-institutional records. When a beneficiary has double coverage (medical benefits coverage by both TRICARE and another medical/hospital insurance, medical service, or health plan except Medicaid or a plan supplemental to TRICARE) TRICARE is always the secondary coverage. Therefore, the amount paid by other double coverage plans must be shown on the claims (or attached EOB worksheets), and entered on the claim record to effect proper TRICARE reimbursement. If the provider of care is owned or operated by the contractor or is in a clinic or other facility operated by the contractor as an employee or subcontractor, the other health insurance shall also be collected by the contractor or its designee. The other insurance EOB/worksheet may cover various physicians and/or dates of service. The amount applicable to the particular TRICARE claim being processed must be determined and entered on the claim records. This is required information.

On DRG claims, where the DRG-based amount is greater than the hospital's actual billed charge, and the primary insurance has paid the full billed charge, TRICARE will pay the difference up to the DRG amount. If the OHI payment equals or is greater than the DRG-based amount, no additional payment can be made.

Supplement plans do not fall within the definition of double coverage. Income maintenance plans which pay the beneficiary a flat amount per day, week or month while the beneficiary is hospitalized or disabled are not considered double coverage or supplemental plans. They usually do not specify a type of illness, length of stay, or type of medical service required to qualify for benefits and benefits are not paid on the basis of incurred expenses. TRICARE will pay benefits without regard to the beneficiary's entitlement to an income maintenance plan.

Payment Error: The following may constitute payment errors:

1. Other insurance payments shown on claim/attachment but not considered in the payment which results in an incorrect reimbursement.

2. Incorrect amount of other insurance payment entered resulting in an incorrect reimbursement.

3. TRICARE paid primary when other coverage is primary.

4. Supplemental plan coverage applied as primary payer.

AMOUNT PAYMENT PEN (09G) This is an 9 position signed numeric field including two decimal places which is the total mont of payment withheld by the contractor. This is required information.

Payment Error: A payment error may be present if the managed care contractor did not correctly apply the payment penalty when a preauthorization for services was not issued.

AMOUNT OF THIRD PARTY LIABILITY (04G) This is an 9 position signed numeric field including 2 decimal places which is the total amount paid by outside party (excluding patient's other health insurance coverage) e.g., third party liability for services reported on the record. Any inpatient claim that has a diagnosis code in the range 800-999.9 regardless of the dollar value, and any outpatient claim within the same code range with billed charge of $500 or

more are considered potential TPL claims. This is required information on both the institutional and non-institutional record.

Payment Error: Any claim that falls within the diagnosis and billed charge parameters where no TPL development or information is included may result in a payment error.

AMOUNT PAID BY GOVERNMENT CONTRACTOR (08G) This is an 9 position signed numeric field including 2 decimal places which is that portion of total amount allowed that was paid by government contractor for the services reported on the record. This is required information on both the institutional and non-institutional record. The field reflects the total amount paid regardless of a provider's financial arrangement with the contractor, i.e., "withhold amounts'.

The amount due is determined as follows:

1. If no other insurance is involved, the amount will be the total allowed
amount less deductible and patient's coinsurance/copayment.

2. If other insurance is involved, the TRICARE payment is calculate using the three step computation contained in the Operations Manual.

3. If other insurance is involved and the claim is for inpatient hospital care from a nonexempt DRG provider, the TRICARE payment will be calculated as described in the TRICARE Reimbursements Manual, Chapter 4, Section 4.

Reference: TRICARE Reimbursements Manual, Chapter 4, Section 4; and ADP Reporting Manual Chapter 2. Locator 1-155 on the institutional record and 2-155 on the non-institutional record.

Payment Error: The following may constitute payment errors:

1. Amount of payment is incorrect.

2. Nonpayable claim paid and vice versa.

3. Payment made to wrong provider.

4. Claim paid on participating basis when it should have been reimbursed on a
non-participating basis and vice versa.

5. Payment duplicates payment on previous claim.

BEGIN DATE OF CARE (Institutional) (05D) This is an 8 position numeric field which contains a YYYYMMDD value and is the earliest date of care reported on the institutional record. This is required information.

Payment Error: The following may constitute payment errors:

1. Date of service is past the claims filing deadline and no waiver has been

granted by the contractor.

2. Beneficiary is ineligible on correct date of care. (Refer to TRICARE Reimbursement Manual, Chapter 6, Section 2 for the effects of ineligibility on DRG priced claims.)

BEGIN DATE OF CARE (Non-Institutional) (06I) This is a 8 position numeric field which contains YYYYMMDD values on the non-institutional record. This field contains the earliest beginning date of the provider's services for that episode of care unless the treatment encounter data is split for HCSR reporting purposes, e.g., split because of multiple providers, care crosses fiscal years on non-institutional claims, or data contains multiple types of services. (Refer to ADP Manual, Chapter 1, Section 3.2.4 and Operations Manual, Chapter 8 Section 8.7.0 for more information on HCSR claim breakdowns). This is required information.

Payment Error: The following may constitute payment errors:

1. Inclusive dates of care overlap two fiscal years, which results in incorrect deductible.

2. Date of service is past the claims filing deadline and no waiver has been granted by the managed care contractor.

3. Beneficiary is ineligible on date of care.

4. Provider is not authorized for date of care.

BILL CLASSIFICATION CODE (08D) This is a 1 position alphanumeric field which describes the type of billing from the facility on the institutional record. On the UB-92, Form Locator 4. this code is the second digit in this three-digit field: the first digit being the type of facility, the second is the bill classification e.g., inpatient, outpatient, etc., and the third digit is the frequency, e.g., admit thru discharge, interim, late charge, etc. This is required information.

Payment Error: None.

DATE HCSR PROCESSED TO COMPLETION (09A) This is an 8 position numeric field on both institutional and non-institutional records which contains the values YYYYMMDD and is the date the contractor processed the HCSR to completion. Claims are processed to completion when the benefits are paid, denied, or applied to the deductible. The date on the HCSR must be the same as the date on the check and EOB. This is required information on both the institutional and non-institutional record.

Payment Error: None.

DEERS DEPENDENT SUFFIX (04B) This is a 2 position alphanumeric field on both institutional and non-institutional records that uniquely identifies the patient within the family on the DEERS database. This is required information except for those HCSRs that are excepted from the query response. A dump code can be used on those claims denied without a query. See ADP Manual, Chapter 2, Section 4.

CLAIMS AUDIT GUIDELINES

Payment Error: Payment to an ineligible beneficiary.

DENIAL REASON CODE (04H on institutional record and 10I on non-institutional record) This is a 2 position alphanumeric field that identifies the reason for nonpayment of services on the detail line item. It is required if services are not allowed. Leave blank if not applicable.

Payment Error: Claims denied or allowed in error are payment errors.

DIAGNOSIS EDITION IDENTIFIER (16A) This is a 1 position alphanumeric field that identifies the edition number of the International Classification of Diseases used in determining the diagnosis codes on both types of records. For institutional records only, it also identifies edition number for determination of Operation/Non-Surgical procedures. This is required information.

Payment Error: None.

DISCHARGE STATUS (04D) This is a 2 position alphanumeric field that indicates the patient status as of the end date of care on the HCSR for institutional claims. The discharge status can be found on the UB-92 claim form under the heading 'patient status" in Form Locator 22. This is required information.

Payment Error: The following may constitute payment errors:

1. DRG payment erroneously based on a transfer instead of discharge and vice versa.

2. DRG payment when patient status is "remaining" except when claim qualifies for interim payment.

DRG GROUPER REVISION (18A) This is a 2 position alphanumeric field on the institutional record which identifies the Diagnosis Related Grouper used to determine the DRG. This is a required field if the treatment encounter is processed under the DRG reimbursement methodology.

Payment Error: DRG payment error may result based on wrong grouper version.

DRG NUMBER (10E) This is a 3 position unsigned numeric field which identifies the Diagnosis Related Group (DRG) determined for this care on an institutional record. This is required if the HCSR is processed under the TRICARE DRG reimbursement methodology. The auditor will verify the HCSR entry with the 3M Health Systems Information (HIS) DRG Grouper program on the personal computer.

Payment Error: The following may constitute payment errors:

1. Payment based on erroneous DRG number.

2. DRG reimbursement for number exempt from DRG payment.

3. Erroneous outlier determinations.

4. DRG payment based on erroneous weighing factors.

CLAIMS AUDIT GUIDELINES

DRG PRICER REVISION (19A) This is a 2 position alphanumeric field on the institutional record which identifies the Diagnosis Related Pricer used to determine the DRG. This is required if the HCSR is processed under the DRG reimbursement methodology, otherwise field should be blank.

Payment Error: Payment errors may result based on erroneous DRG pricer.

END DATE OF CARE (Institutional) (06D) This is an 8 position numeric field which contains a YYYYMMDD value and is the latest date of care reported on the institutional HCSR. This is required information.

Payment Error: The following may constitute payment errors:

1. Date of service is past the claims filing deadline and no waiver has been granted by the Managed Care contractor.

2. Beneficiary is ineligible on date of care.

END DATE OF CARE (Non-institutional.) (07I) This is a 8 position numeric field which contains YYYYMMDD values on the non-institutional record. This field contains the latest ending date of the Provider's services for this procedure unless the treatment encounter data is broken down for HCSR reporting purposes. e.g., breakdown because of multiple providers, multiple fiscal years (outpatient non-institutional claims only) or multiple types of services or multiple NASs. This is required information. Reference: ADP Manual, Chapter 1, Section 3, 2.4, for additional information on claim breakdown.

Payment Errors: The following may constitute payment errors:

1. Inclusive dates of care overlap two fiscal years, which adversely affects the deductible.

2. Date of service is past the claims filing deadline and no waiver has been granted
by the contractor.

3. Beneficiary is ineligible on date of care.

ENROLLMENT STATUS (12B) This is a 2 position alphanumeric field on both the institutional and non-institutional records indicating whether the patient is enrolled with the contractor (Prime) or not (Non-Prime), or the care was received under the Standard TRICARE Program or the care was received under the Continued Health Care Benefit Program (CHCBP). This is required information.

Payment Error: A payment error exists if the contractor processed the claim under the incorrect enrollment status which resulted in an overpayment or underpayment.

FILING DATE (01A) This is a 7 position numeric field with YYYYDDD value which is the date the request for payment of services rendered was received by the contractor for processing. This field is part of the Internal Control Number

group composed of the Filing Date, Filing State/Country Code, and Sequence Number. Generally, the date entered by the contractor is not questioned unless there is evidence that it is incorrect, e.g., the date is earlier than a date of service on the claim or the claim is a reprocessing of a previously denied claim and has not been assigned a new claim number. This is required information on both the institutional and non-institutional records.

Payment Error: If the filing date is earlier than the date of services on the claim, a payment error may exist if the contractor paid for services not yet rendered.

FILING STATE/COUNTRY CODE (02A) This is a 2 position alphanumeric field that indicates the State or Country where the primary care was provided. This field is part of the Internal Control Number group composed of the Filing Date, Filing State/Country Code, and Sequence Number. This information is required on both institutional and non-institutional record.

Payment Error: Claims processed for care provided outside the contractor's contractual jurisdiction would result in a payment error.

FREQUENCY CODE (07D) This is a 1 position alphanumeric field that describes the frequency of billing from the institution on institutional records. On the UB-92 claim form, the frequency information can be found at Form Locator 4. This is required information.

The Initial, Interim, and Final HCSRs, when used, must be submitted to TMA in correct sequence. If the patient is transferred and the care is processed under DRG rules, then Code '1' must be used; all other Transfers must use Code '1' or '4' as appropriate.

Payment Error: A non-qualifying interim claim processed for payment under the DRG pricing methodology may result in a payment error.

GOVERNMENT AUTHORIZED BED DAYS (10D) This is a 3 position signed numeric field on institutional claims which contains the number of hospital days authorized for all services within the HCSR. This is required information on the HCSR. The number of hospital days is to be entered where there was any allowance by the contractor. If initial, interim or final statement the number of allowed days in the period covered by the HCSR is entered. The day of admission is to be counted as a hospital day and the day of discharge is not to be counted as a hospital day. If the claim is for the initial or interim billing, i.e., disposition is 'remaining', the number of days is to include the last day of the billing. Example of determination of interim/final bill hospital days:

Initial Billing - Admitted March 10
Billing is through March 31. Number of days = 22.

Interim Billing - First date is April 1
Billing is through April 30. Number of days = 30.

Final Statement - First date is May 1.
Discharge date is May 21. Number of days = 20.

CLAIMS AUDIT GUIDELINES

Payment Error: Incorrect calculation of hospital days resulting in incorrect allowance of room charges or erroneous calculation of coinsurance/copayment may be assessed payment errors.

HEALTH CARE SERVICE RECORD (HCSR) SUFFIX (04A) This is a 1 position alpha field on both institutional and non-institutional records that identifies when treatment encounter data is split for HCSR reporting purposes. It is used to link separate Health Care Service Records to combinations of health care submitted at one time. The codes are assigned in alphabetic order. Under certain conditions, treatment encounter data must be reported on separate HCSRS. (See ADP Manual, Chapter 1. Section 3). The first HCSR must be reported with a suffix = A, the next HCSR with suffix = B, and so on. If treatment data does not need to be split, the suffix must be A. This is required information.

Payment Error: Payment made on the same HCSR for services from multiple providers. However, there is no payment error when the individual provider is in the same group of providers or the same clinic.

HEALTH CARE PLAN CODE (10A) This is a 2 position alphanumeric field on both institutional and non-institutional records that identifies the Health Care Plan that the Provider was affiliated with when the care was rendered. This is required information.

Payment Errors: None

PRICING LOCALITY CODE (09C) The assigned locality code for the physical location where the provider is physically located/or rendered the service. This is required information.

MTF (10C) Four digit DMIS code from the catchment area directory.

NAS EXCEPTION REASON (13A) This is a 2 position alphanumeric field on both institutional and non-institutional records that describes the reason for bypassing the requirement of a Nonavailability Statement (NAS). The NAS Exception Reason is required if applicable to the HCSR. When no NAS exceptions apply for outpatient care or for inpatient care (including outpatient maternity) for beneficiaries residing within the catchment area, the field must be blank. The field must also be blank if the beneficiary resides outside a catchment area. This is required information. Reference: TRICARE Policy Manual Chapter 11, Section 2.1 for additional information.

Payment Error: The following situations may result in payment errors:

1. Beneficiary zip code indicates NAS is required, no exception reasons apply and Nonavailability Statement is not with claim or on DEER's.

2. NAS Exception Reason coded when none apply and payment made based on exception code.

NONAVAILABILITY STATEMENT (NAS) NUMBER (14A) This is an 11 position alphanumeric field on both institutional and non-institutional records that is the unique number assigned by the MTF when issuing the NAS. This is required information. The NAS number represents the following information:

CLAIMS AUDIT GUIDELINES

1. The first 3 digits are the Data Management information System (DMIS) facility identifier.

2. The next four digits represent the date the form is issued and are the last digit of the year plus the Julian Day (For example, if the date is 1 January 1991 these digits would be 1001).

3. The final three digits are the facility sequence number.

Payment Error: If the Nonavailability Statement number does not correspond to the inpatient admission for this HCSR a payment error may be assessed.

NAS ISS RSN CD (24A) This is a 1 alphanumeric field on institutional and non institutional record. The reason for issuance code indicates why the care was not or cannot be provided by a Military Treatment Facility. This is required information.

NUMBER OF BIRTHS (11D) This is a 1 position signed numeric field on the institutional record which designates the number of births, both live and stillborn, occurring during delivery. This data is required for delivery claims and must be developed if not received in the treatment encounter data. This data is to be reported on the mother's HCSR only. V codes are to be used to define 1, 2 or multiple births and number of births must agree with the diagnosis code.

Payment Error: None.

NUMBER OF SERVICES (02I) This is a 2 position signed numeric field on the non-institutional record which is the number of procedures performed/services or supplies rendered for medical, dental, and mental health care. Identical procedures must be combined when performed by the same provider, with the same charge for each, and within the same calendar month, provided the reason for allowance/denial is the same for each charge, with the exception of psychiatric procedures. For ambulance services, allergy testing, DME rental. POV mileage for PFPWD, or anesthesiology, enter 01 for each service regardless of length of time, number of base units or mileage. Allowed prescription drugs must be combined separately from disallowed prescription drugs. This is required information.

Payment Error: An-incorrect entry which results in an erroneous calculation of the allowed amount may result in an incorrect payment.

OCCURRENCE NUMBER (05H on institutional records and 11I on non-institutional records). This is a 2 position unsigned numeric field which is the unique number for each utilization or revenue data occurrence within the HCSR on both institutional and non-institutional records. Occurrence counters must be assigned in sequential ascending order. There can be up to 50 occurrences for institutional records and up to 25 occurrences for non-institutional records. This is required information on the HCSR.

Payment Error: None.

OVERRIDE CODE: (15A) This is a 6 position alpha field that provides indication that questionable information has been verified on both

institutional and non-institutional records. This data is required if an override code is applicable to override TMA edit checking. One to three codes may be reported in the field and must not be duplicated. The field must be left justified and blank filled. The only codes that are valid are those listed in the ADP Manual, Chapter 2, Section 6 (M-O).

Payment Error: The following may result in payment errors when an override code is incorrectly used:

1. Ineligible beneficiary due to Medicare eligibility (over age 65).

2. No authorization for good faith payment.

3. Claim filed after filing date paid without a waiver, or waiver granted inappropriately.

4. Ineligibility.

5. Claim does not qualify as a successive admission.

6. Catastrophic cap limit has not been reached.

7. DRG related cost-share not applicable on a non-DRG claim.

PATIENT COINSURANCE (05G) This is an 8 position signed numeric field on both institutional and non-institutional records which includes 2 decimal place. This is the amount (percentage) of allowed charges that beneficiaries are required to pay. This is required unless a unique Health Care Plan Code allows only partial submission of financial data.

Payment Error: The following may result in payment errors:

1. Incorrect determination of the allowed amount.

2. Incorrect application of the outpatient deductible.

3. Incorrect sponsor status.

4. Type of service incorrect, e.g., inpatient versus outpatient.

PATIENT COPAYMENT (07G) This is an 8 position signed numeric field including 2 decimal places on both institutional and non-institutional records. This is a predetermined, fixed amount charged by the contractor under TRICARE PRIME, other demonstrations, or the fixed amounts under the standard TRICARE program that the beneficiary is liable for paying for covered services. For standard TRICARE program, co-payment must be calculated in accordance with the TRICARE Reimbursement Manual, Chapter 2, Section 1. Co-payment must be calculated in accordance with established fees for service, if other than standard TRICARE program. This is required information.

Payment Error: The following may result in payment errors:

1. Under TRICARE PRIME the copayment was not reported in accordance with the established fee.

CLAIMS AUDIT GUIDELINES

2. Under Standard TRICARE, an incorrect PFPWD copayment was reported based on the wrong sponsor grade or incorrect hospital daily rate for dependent of active duty sponsor was reported.

PATIENT DATE OF BIRTH (03B) This is an 8 position numeric field which contains the values YYYYMMDD on both institutional and non-institutional records. This is the patient's date of birth as verified through DEERS. The patient's DOB in some instances determines the patient's continued eligibility under the program. Children lose TRICARE eligibility at age 21 unless handicapped or enrolled as a full time student in a school of higher learning. Student eligibility terminates at age 23. DEERS or the patient's ID card must reflect the continued eligibility for claims to be paid. This is required information. Reference: ADP Manual, Chapter 9, Section 3 for specific instructions.

The auditor will verify that the correct DOB is coded and confirm eligibility and age on DEERS. If the patient is over age 21 or the patient is over 65, the auditor will verify the appropriate coding of the Override Code.

Payment Errors: Payment of claims for services to an individual who lost eligibility, or denial of claims for services to an individual who is eligible will result in a payment error.

PATIENT NAME (0IB) This is a 27 position alphanumeric field on both institutional and non-institutional records which contains the legal name of patient, as verified through DEERS. Last name must be at least one (1) character followed by a comma. The name is in free form format (after downloading from DEERS) Last Name, a comma, First Name, a comma, Middle Initial. If unavailable from DEERS the name from the claim or treatment encounter data should be used. A separate claim form is required for each patient. Variations in spelling are not permissible, since this may cause the creation of additional beneficiary history files, erroneous applications of coinsurance/copayments and deductibles. This is required information.

Designations such as Jr., II, III, etc. must be appended directly to last name with no delimiter.

Payment Error: Incorrect coding of the patient's name may cause an incorrect deductible or coinsurance/copayment.

PATIENT RELATIONSHIP TO SPONSOR (11B) This is a 1 position alphanumeric field on both institutional and non-institutional records that defines the relationship of the patient to the sponsor, as verified through DEERS. This is required information on both the institutional and non-institutional record.

Payment Error: The following may result in payment errors:

1. Relationship coded "X" for "Other" (good faith) and paid when the good faith
payment was not authorized by TRICARE Management Activity.

2. Payment based on incorrect relationship of Former Spouse (H), (R), (T) or (Y).

CLAIMS AUDIT GUIDELINES

3. Payment made when sponsor is active duty and relationship is sponsor.

PATIENT SEX (05B) This is a 1 position alphanumeric field on both institutional and non-institutional records that defines the sex of the patient. This information must be downloaded from DEERS, but if unavailable from DEERS the information should be developed. DEERS value "Z" (unknown) is not allowed. This is required information on both the institutional and non-institutional records.

Payment Error: None.

PATIENT SSN (02B) This is a 9 position alphanumeric field on both institutional and non-institutional records which contains the patient's social security number. If SSN is unknown, the field should be blank filled. Erroneous entries may indicate the existence of multiple beneficiary history files for the same beneficiary or sponsor and erroneous application of the deductible or coinsurance/copayment. If a SSN is entered, it must be valid, and can be verified on DEERS. This is required information on both the institutional and non-institutional record.

Payment Error: An incorrect application of deductible or coinsurance/copayment will result in a payment error.

PATIENT ZIP CODE (06B) This is a 9 position alphanumeric field on both institutional and non-institutional records which is the US Postal Zip Code or foreign country code for patient's legal residence at the time service was rendered and must not be the zip code of a P.O. Box. Field must be a valid 5 or 9 digit zip code. If only 5 digits, left justify and blank fill to right. If a foreign country, must be a 2 character foreign country code, left justified and blank filled. The contractor is not responsible for an error if the entry on the claim is incorrect.

The address on the EOB/check must agree with that on the claim form or attachment to assure deliverability unless there is some evidence that the patient has subsequently moved or that a secondary mailing address is appropriate, e.g., address of a custodial parent. This is required information on both the institutional and non-institutional record. The patient zip code must be the residence at the time the care was rendered.

Payment Error: A payment error exists if, because of an incorrect zip code, a claim is paid when a valid Nonavailability Statement is required and not provided or, conversely, if a claim is denied for lack of a Nonavailability Statement when one is not required.

PLACE OF SERVICE (08I) This is a 2 position alphanumeric field on the non-institutional record that indicates the location of provided health care, e.g., inpatient-hospital, doctor's office, ambulance, etc. This is required information.

Payment Error: Incorrect place of service may cause payment errors due to benefit determinations, pricing errors, etc.

PRICING CODE (05I) This is a 2 position alphanumeric field on the non-institutional record which indicates the contractor's pricing methodology

used in determining the amount allowed for the service(s)/supplies. Code '0' must be used for all HCSR drug charges and for denied services/supplies. This is required information.

Payment Error: The following may result in payment errors:

1. Incorrect pricing methodology causing an error in the amount allowed.

2. Service/supply incorrectly denied.

3. Service/supply incorrectly allowed.

PRICING PROFILE (12I) This is the 2 position alphanumeric field on the non-institutional record which identifies the pricing profile used to determine the allowable charge. This is a required field if the pricing code = 2, 3, 6, 7, 8, A, or B.

Payment Error: If incorrect pricing profile is used for date of service, a payment error may result.

PRINCIPAL OPERATION/NONSURGICAL PROCEDURE CODE (07E) This is a 5 position alphanumeric field on the institutional record that identifies the principal procedure performed during the period covered by the HCSR as coded on the UB-92. On the UB-92 claim form, this data is found in Form Locator 80. Must limit to the 4 of the 5 positions available. The most current procedure code edition as directed by TMA, and the most detailed code provided must be used. The field is left justified and blank filled. The decimal point is not coded and is always assumed to follow the second position. This is required information when Revenue Codes 36X or 72X are present. The field is to be blank filled if not applicable.

Payment Error: A claim paid without evidence of prepayment medical review when required based on procedure code may result in a payment error.

PRINCIPAL TREATMENT DIAGNOSIS (01F on non-institutional records or 02E institutional records) This is a 5 position alphanumeric field on both institutional and non-institutional records. This is the condition established, after study, to be the major cause for the patient to obtain medical care as coded on the claim form or otherwise indicated by the provider. This data can be found on the UB-92 claim form in Form Locator 67. Must limit to the 5 of the 6 positions available. The most current code must be used as directed by TMA and the most detailed code must be provided. The field is left justified and blank filled. The decimal point is not coded since it is always assumed to be following the second position. The principal treatment diagnosis is generally needed for making determinations about whether or not services are covered, medically necessary, and consistent with other claims data or patient history.

The exact coding taken from the UB-92 must be used on institutional claims, however, on non-institutional claims; the auditor has discretion for the code used. If both a code and a narrative description are given by the provider, but are inconsistent with each other the narrative takes precedence in determining the code to be used. This is required information.

CLAIMS AUDIT GUIDELINES

Payment Error: The following may result in payment errors:

1. Principal Treatment Diagnosis indicates that services are not covered, but were allowed.

2. Principal Treatment Diagnosis indicates that services are covered, but were denied.

3. Principal Treatment Diagnosis is missing, incomplete or unclear to support payment determination.

4. Medical review required but not performed. Justification for payment is questionable.

5. Payment made without development for diagnosis; no documentation to support code used.

PROCEDURE CODE (01I) This is a 5 position alphanumeric field on the non-institutional record indicating the procedure which describes the care received. Procedures must be itemized and coded in accordance with the Physician's Current Procedural Terminology (CPT-4), or HCPCs National Level II Medicare Codes or TMA approved codes contained in the ADP Manual, Chapter 2, Addendum E. If the contractor is using a different internal coding structure, there must be proper conversion to the approved coding on the HCSR. Providers may submit procedure codes in lieu of narrative descriptions. If the provider furnishes an acceptable code plus a nonspecific narrative which does not essentially contradict the code, the code may be used to code (price) the service without further consideration. If the code and narrative disagree, the claim must be developed. A "not elsewhere classified" (NEC) code is to be used only where there is no established procedure code. However, if a specific narrative is provided which is inconsistent with the code, the code representing the narrative can be used without development. This is required information on the HCSR.

Payment Error: Payment errors may result in situations involving use of an incorrect procedure code, unjustified change of a submitted code, or inappropriate use of an NEC code which causes incorrect pricing, denial of a benefit, or failure to apply required medical review guidelines.

PROCEDURE TEXT IDENTIFIER (17A) This is a 1 position alphanumeric field on the non-institutional record which identifies the edition number of the Physician's Current Procedure Terminology used in determining the procedure codes on the HCSR. This is required information on the HCSR.

Payment Error: None.

PROGRAM INDICATOR (05A) This is a 1 position alphanumeric field on both institutional and non-institutional records which identifies the TMA program the services being reported relate to. (See ADP Manual, Chapter 1, Section 3 for further instructions). This is required information on the HCSR.

Pavment Error: If a claim is coded into an erroneous program, cost-share or deductible errors could result.

CLAIMS AUDIT GUIDELINES

PROVIDER CONTRACT AFFILIATION - CODE (03C) This is a 1 position alphanumeric field on both institutional and non-institutional records which indicates whether the provider is under contract with the contractor. This is required information on both the institutional and non-institutional record.

Payment Error: A payment error may exist if the provider was paid by the contractor or subcontractor as a contracted provider when the provider was not under a contract and vice versa.

PROVIDER SPECIALTY (07C) This is a 2 position alphanumeric field that describes a non-institutional provider's major specialty. The provider specialty on the HCSR must match the provider major specialty code in the corresponding record in the provider file and be compatible with the type of services provided. For example, if the payment record shows specialty 59 (ambulance) and type of service is psychotherapy, an occurrence error would be assessed for incorrect specialty code. Since the Operations Manual does not provide specific instructions, contractors can code "clinics" with the specialty code "70" or with the specific code for the appropriate specialty, e.g., "30" for a radiology clinic. If the process to completion date on the HCSR on or after April 30, 1999, the provider major specialty code "70" the major specialty of the provider in the clinic who provided the services must be reported. This is required information.

Payment Error: None.

PROVIDER PARTICIPATION INDICATOR (08C) This is a 1 position alpha character on both institutional and non-institutional records that indicates whether or not the provider accepted assignment of benefits for services rendered. On the UB-92 claim form, this information can be found in Form Locator 53. The provider participation agreement is in block 27 of the HCFA Claim Form 1500 and block 32 of the DD Claim Form 2520 (this form is only used for services rendered in foreign countries). All network providers must participate under the terms of their agreement with the contractor. A non-network provider agrees to participate if the participating block is checked "yes" and the provider signs the claim. If intent to participate is questionable and the non-network provider is known to routinely participate, the contractor shall contact the provider to determine intent. All claims processed under the DRG reimbursement methodology must be participating. This is required information on both the institutional and non-institutional record.

In all cases where the contractor has documented knowledge of payment by the beneficiary or other party, the payment shall be appropriately disbursed, including, when necessary, splitting payment. If the non-network provider is clearly not participating or the intent cannot be determined, the beneficiary is to be paid.

Payment Error: A participating claim paid on a nonparticipating basis or a non-participating claim paid on a participating basis my result in a payment error.

PROVIDER STATE OR COUNTRY CODE (04C) This is a 2 position alphanumeric field on
both institutional and non-institutional records which is used to identify the state or foreign country in which the care was received. This is required information on both the institutional and non-institutional record.

CLAIMS AUDIT GUIDELINES

PROVIDER SUB-IDENTIFIER (02C) This is a 4 position alphanumeric field on both institutional and non-institutional record which is the identification number that uniquely identifies multiple providers using the same Taxpayer Identification Number (TIN). See Provider Sub-Identifier (Locator 3-010) in the Provider Record Data section of the ADP Manual, Chapter 7, Section 1, for more information. The provider Sub-Identifier shown by the contractor on their provider file for the particular provider is to be coded in this field. The field is to be zero filled if no multiple providers exist within the TIN. This is required information on both the institutional and non-institutional record.

Payment Errors: A payment error may exist if the Sub-Identifier is for the wrong provider and affects the determination of the allowable amount. For example, the care provided in a clinic is one-hour of psychotherapy for which the contractor used the Sub-Identifier for a Psychiatrist when the services were actually rendered by a Clinical Social Worker.

PROVIDER TAXPAYER NUMBER: (01C) This is a 9 position alphanumeric field on both institutional and non-institutional records which is the IRS Taxpayer Identification Number (TIN) assigned to the institution/provider supplying the care. For institutions, the TIN must be a 9-digit Employer Identification Number (EIN). For individual providers, a 9-digit EIN or SSN must be used, if available. If not available, report the contractor-assigned number. (See Provider File data element Provider Taxpayer Number 3-005 in the provider record for instructions). Report all nines for transportation services under Program for Persons with Disabilities and for Drug Program when the services are from a non-participating pharmacy. This is required information on both the institutional and non-institutional record.

Payment Error: Payment made to the wrong provider due to incorrect entry and payment to a provider when a "dummy" number is coded may result in a payment error.

PROVIDER ZIP CODE (05C) This is a 9 position alphanumeric field on both institutional and non-institutional records which is the providers zip code of the location where the care was provided. The entry must be a valid zip code or blank if a foreign country and must be developed if not received in the treatment encounter data. If all 9-digits are not available, the first 5 digits are used, left justified and blank filled. The first 5-digits are required. For professional claims: P.O. Box zip codes may be used if the care provided is radiology, pathology or anesthesiology. Enter the MTF zip code if the care is rendered by a Partnership provider in an MTF. Enter the beneficiary's zip code if the Program Indicator is 'D' (Drug) and the pharmacy does not participate. This is required information on both the institutional and non-institutional record.

Payment Error: Incorrect amount allowed may occur if zip code for location of care is incorrect.

REASON FOR ADJUSTMENT (07A) This is a 1 position alphanumeric field on both institutional and non-institutional records which indicate the primary reason for the positive (A through C) or negative (D through F) HCSR and the source

of error (non-contractor, contractor, prior contractor). The information in this field is required if applicable to HCSR conditions.

Payment Error: Adjustment to pay additional amount when none is required may be a payment error.

REASON FOR PAYMENT REDUCTION (26A) This is a 1 position alphanumeric field on both institutional and non-institutional records which indicates the reason payment reduction was assessed: (A) Mental Health Pre-Authorization Not Obtained, (B) Adjunctive Dental Care Pre-Authorization Not Obtained or (C) Procedure/ Services in TRICARE Regions Care Not Authorized. This is required information on both the institutional and non-institutional record.

Payment Error: Payment reduction applied incorrectly or not appropriately applied.

RECORD TYPE (21A) This is 1 position numeric character on both institutional and non-institutional records which indicates the type of record. It can only be Code 1 for institutional, or Code 2 for non-institutional records. This is required information.

Payment Error: Institutional claims processed as non-institutional or non-institutional claims processed as institutional may result in a payment error.

NUMBER OF PAYMENT REDUCTION DAYS/SERVICES (27A) This is a 3 signed numeric field which indicates the number of payment reduction days/services that were assessed. If not applicable, zero fill. For Institutional records, number of payment reduction days shall be reported. For Non-Institutional records, number of payment reduction days for partial hospitalization program or number of provider services shall be reported. This is required information.

Payment Error: Number of reduction days/services miscalculated.

REVENUE CODE (01H) This is a 4 position alphanumeric field on the institutional record which identifies revenue categories associated with the type of service rendered. Like revenue codes should be summarized to one occurrence for reporting on the HCSR. Room and board revenue codes can be summarized if the code and rate are the same. Denied revenue codes must be reported as separate occurrences on the HCSR. Revenue code 001 (Total Charge) must be reported for each HCSR and units of service must be zero. On the UB-92 claim form, the Revenue Code and Revenue Description are found in Form Locators 42 and 43. This is required information.

Payment Error: An incorrect revenue code which allows payment for a non-covered service/supply or a higher or lower room rate allowance may result in a payment error.

REVENUE DATA OCCURRENCE COUNT (20A) This is a 2 position numeric field on the institutional record which shows the number of sets of revenue codes and related data elements that occur on the record. The number must be greater than 0 and less than 51. This is required information.

Payment Error: None.

CLAIMS AUDIT GUIDELINES

SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODES (08E and 09E) There are two data element fields each containing 5 alphanumeric characters on the institutional record which identify the procedures, other than the principal procedure, performed during the period covered by the HCSR. The most detailed procedures must be coded. Must limit to 4 of 5 positions available. Must be left justified and blank filled. Do not code a decimal point which is always assumed to follow the second position. On the UB-92 claim form, this information is found in Form Locators 81. If a secondary operation/non-surgical procedure is known but not present on the treatment encounter data, the code must be developed. This information is required if available, if not available blank fill.

Payment Error: The amount paid on claims subject to DRG reimbursement may be affected by secondary procedure codes if their presence (or absence) causes an incorrect DRG assignment.

SECONDARY TREATMENT DIAGNOSIS (02F through 05F) There are four data element fields on the non-institutional record and eight data element fields on the institutional record. Both the non-institutional and institutional records contain 5 alphanumeric characters which correspond to the additional conditions that coexist at the time of admission or during the treatment encounter. The most current diagnosis edition as directed by TMA must be used. Must limit coding of the Secondary Treatment Diagnosis codes on the HCSR to 5 of the 6 positions available. On the UB-92 form, this information can be found in Form Locators 68. These fields are required if available. Code must be left justified and blank filled. Do not code the decimal point, which is always assumed to be following the third position. Blank fill if not available. If a secondary treatment diagnosis is known to exist, but is not on the treatment encounter data, this code must be developed.

Payment Error: The amount paid on claims subject to DRG reimbursement may be affected by secondary diagnosis codes if their presence (or absence) causes an incorrect DRG assignment.

SEQUENCE NUMBER (03A) This is a 5 position alphanumeric field on both institutional and non-institutional records which is a sequential number assigned by the contractor to identify the individual HCSR. Along with the Filing Date, Filing State/Country Code, the sequence number comprises the Internal Control Number (ICN). Once assigned, the sequence number cannot be reused with the same Filing Date, Filing State/Country, and HCSR Suffix. This is required information.

Payment Error: None.

SOURCE OF ADMISSION (03D) This is a 1 position alphanumeric field on the institutional record which indicates the admission referral source. On the UB-92 claim form, this information is found in Form Locator 20. The source of admission codes include a special code structure to be used. This is required information. Reference: ADP Manual, Chapter 2, Section 8 (Q-S) for additional information.

Payment Error: None.

SPECIAL PROCESSING CODE (11A) This is a 6 position alphanumeric field on both institutional and non-institutional records which indicates care that

requires special processing. This is a required field if HCSR processing is applicable to special processing conditions. One to three codes may be reported and may not be duplicated. This is required information. Reference: ADP Manual, Chapter 2, Section 8 (Q-S) for a complete list of codes.

Payment Error: The following may result in payment errors:

1. Payment made to a civilian provider for a bone marrow transplant without authorization.
2. Payment made for a liver transplant which is specified as contradiction in the policy manual.

SPECIAL RATE CODE (12A) This is a 2 position alphanumeric field on both institutional and non-institutional records which indicates care that requires a special rate. If no special rate applies, field is to be blank. This is required information. Reference: ADP Manual, Chapter 2, Section 8 (Q-S) for a complete list of codes.

Payment Error: Payment not in compliance with applicable special rate, e.g., DRG, or payment based on special rate when none applies.

SPONSOR BRANCH OF SERVICE (09B) This is a 1 position alphanumeric field on both institutional and non-institutional records which contains the sponsor's uniformed service branch or organization as verified through DEERS. This information is to be downloaded by the contractor from DEERS and if not available the branch of service from the claim or treatment encounter may be used. 'X" and "Z' are not allowed. This is a required field.

Payment Error: None.

SPONSOR PAY GRADE (08B) This is a 2 position alphanumeric field on both institutional and non-institutional records which contains the sponsor's pay grade as verified through DEERS. The contractor must download this information from DEERS and, if unavailable, report the pay grade from the claim. For HCSRs reporting services under Program for Persons with Disabilities, Sponsor Pay Grade must be one of the following 01-09, 11-15, or 21-31, since the copayment is determined based on the pay grade. This is required information.

Payment Error: PFTH health care service records containing an incorrect sponsor's pay grade which results in an erroneous copayment may result in a payment error.

SPONSOR SOCIAL SECURITY NUMBER (07B) This is a 9 position alphanumeric field on both institutional and non-institutional records which is the sponsor social security number as verified through DEERS. Erroneous entries may indicate the existence of multiple beneficiary history files for the same beneficiary or sponsor and erroneous application of the outpatient deductible or coinsurance/copayment. This is required information.

Pavment Error: An incorrect application of a deductible or coinsurance/copayment may result in payment errors.

CLAIMS AUDIT GUIDELINES

SPONSOR STATUS (I0B) This is a 1 position alphanumeric field on both institutional and non-institutional records which indicates the current status of the sponsor at the time the care was rendered, as verified through DEERS. NATO HCSRs must be reported using code "T" Foreign Military even though DEERS includes them in code 'X' other. This is required information.

Payment Error: A coinsurance/copayment error due to incorrect status code may result in a payment error.

TOTAL BED DAYS (09D) This is a 3 position signed numeric field on the institutional record which is the number of days of hospital care, including all allowed and denied days on the billing. The day of admission is to be counted as a hospital day, while the day of discharge is not to be counted as a Hospital day. If initial, interim, or final statement, the number of days in the period covered by the HCSR is to be entered. This is required information.

Payment Error: Incorrect calculation of hospital days resulting in incorrect allowance of room charges or erroneous calculation of coinsurance/copayment may result in a payment error. On DRG reimbursed claims, an incorrect entry may result in an erroneous allowance.

TOTAL CHARGE BY REVENUE CODE (03H) This is an 9 position signed numeric field on the institutional record which includes 2 decimal places. This is the amount billed by revenue code. Like revenue codes must be summarized to one occurrence for reporting on the HCSR. Room and board revenue codes can be summarized if the code and rate are the same. On the UB-92 claim form, this information is found in Form Locator 47. The total charge (revenue code 001) must be reported for each HCSR. This field is required information.

Payment Error: An incorrect amount reported on the HCSR may result in a payment error.

TOTAL CHARGE FOR PROCEDURE CODE (03I) This is an 9 position signed numeric field on the non-institutional record which is the amount billed by the provider for the service(s)/ supply(ies). Combining charges for the same procedures having the same billed charges under the contractor's "at-risk" operation is optional with the contractor if the same action is taken with all. The option to combine like services shall be applied to those services rendered the same calendar month.

If a lump charge is billed on the claim for several procedures, the contractor must develop for a breakdown of charges unless the billing is for outpatient care from a hospital. This is required information.

Payment Error: The following may result in payment errors:

1. Amount entered for a distinct service differs from the amount on the claim form or itemized bill.

2. Incorrect aggregate total entered for multiple services on one line.

3. Charges not separated (lump amount) for several different procedures processed without adequate documentation or breakdown of charges.

4. Charges not billed on the claim, but appearing on other insurance EOB/worksheet entered as part of the claim.

5. Combined charges that spans two pricing profiles.

TYPE OF ADMISSION (02D) This is a 1 position alphanumeric character on the institutional record which indicates the type of admission. Use of code 4 necessitates the use of special Source of Admission codes (A through D) and must not be used for the mother's charges. On the UB-92 claim form, this information can be found in Form Locator 19. This is required information.

Payment Error: An erroneous medical emergency determination for a patient residing within a catchment area may result in a payment error.

TYPE OF INSTITUTION (06C) This is a 2 position alphanumeric field on the institutional record which describes the type of institution for institutional providers. This data serves to identify the capacity of the facility for the specific care entered on each institutional record. On the UB-92 claim form, the type of institution can be found in Form Locator 4 which is a 3 digit field. The first digit of that entry is the type of facility. Refer to the National Uniform Billing Data Element Specifications manual for the specific codes. For UB-92 claims, the auditor should verify that the TRICARE assigned Type of Institution code is the same as that reported by the provider facility. This is required information on the UB-92 claim form which must be developed if not received in the treatment encounter data.

Payment Error: Payment made for care in a facility requiring TMA approval when such approval does not exist may result in a payment error.

TYPE OF SERVICE (09I) This is a 2 position alphanumeric field on the non-institutional record which indicates the type of service provided. This field actually has two positions to code. Refer to ADP Manual, Chapter 2, Section 9 (T-Z) for a list of first and second position codes. This is required information.

Payment Error: The following may result in payment errors:

1. Erroneous first position code results in an incorrect application of the coinsurance/ copyment.

2. Erroneous second position code results in the application of the incorrect reimbursement methodology, e.g., anesthesia services reimbursed as assistant surgeon charges.

TYPE OF SUBMISSION (06A) This is a 1 position alphanumeric field on both institutional and non-institutional records which indicates the HCSR submission type. This is required information. There are four types of Health Care Service Records which are:

Initial Submission
Adjustment Submission

CLAIMS AUDIT GUIDELINES

Resubmission
Complete Denial

Within the initial and adjustment submissions are various Type of Submission codes which indicate, for example, an initial HCSR submission, adjustment to a prior HCSR data, adjustment to non-HCSR data, etc. Non-HCSR data codes are to be used when a HCSR is being submitted for a claim that was initially processed not using the HCSR format. In these instances, the following Type of Submission codes must be used:

B = Adjustment to non-HCSR data
E = Complete cancellation of non-HCSR submission

Payment Error: Claims denied or paid in error may be payment errors.

UNITS OF SERVICE (by Revenue Code) (02H) This is a 7 position signed numeric field on the institutional record which is the number of services rendered or number of days, by revenue category. Must be equal to or less than 9999. On the UB-92 claim form, this information is found in Form Locator 46. This is required information.

Payment Error: None.

UTILIZATION DATA OCCURRENCE COUNT (20A) This is a 2 position field on the non-institutional record which codes the number of sets of procedure codes and related utilization data elements that occur on the record. This number must be greater than 0 and less than 26. This is required information.

Payment Error: None.

CLAIMS AUDIT GUIDELINES

CHAPTER 5 - ASSESSMENT OF HCSR CONTRACTOR ERRORS

TABLE OF CONTENTS

CLAIMS AUDIT GUIDELINES

CHAPTER 5 - ASSESSMENT OF HCSR CONTRACTOR ERRORS

A. Introduction. This chapter discusses how Health Care Service Record (HCSR) occurrence errors, payment errors, and procedural documentation errors are determined during the claims audit. Related guidelines are in Chapter 3, "Auditing Special Claim Conditions," and Chapter 4, "Auditing HCSR Data Elements." Exhibit 1 at the end of this chapter lists the codes used to indicate errors.

B. Health Care Service Record (HCSR) Occurrence Errors. All HCSR record occurrence errors, including errors in financial fields, are counted and the error rate is expressed as a percentage of the total number of data fields in the HCSR.

1. General. Occurrence errors are assessed for an incorrect entry in any data field of any HCSR record type. Any error, including errors in financial fields, will be counted as occurrence errors. For audit purposes, the occurrence errors on the HCSRs have been assigned special codes which are grouped under the ten categories "A" through "J" below. There are two general types of occurrence errors - those which are associated with specific data fields (error categories "A" through "I,') and those which are not (error category "J"). All occurrence errors assessed are entered in the automated HCSR audit system utilizing the code designating the particular error.

2. Errors Specific to Data Fields. (See Chapter 4 for the names of the specific data fields in the "A" through "I" categories and detailed instructions for auditing these fields.)

"A"	Category Errors	Incorrect Claim Information
"B"	Category Errors	Incorrect Patient/Sponsor Information
"C"	Category Errors	Incorrect Provider Information
"D"	Category Errors	Incorrect Admission/Discharge Information (Institutional HCSR only)
"E"	Category Errors	Incorrect Diagnosis/Treatment Information (Institutional HCSR only)
"F"	Category Errors	Incorrect Diagnosis Information (Non-Institutional HCSR only)
"G"	Category Errors	Incorrect Financial Information
"H"	Category Errors	Incorrect Institutional Revenue Data

CLAIMS AUDIT GUIDELINES

3. Errors not Specific to Data Fields "J" Category Errors for Incorrect/ Unsupported Record Errors are assessed in instances when the contractor is not in compliance with the requirements in the Automated Data Processing and Reporting Manual for reporting entire HCSR records or records within the HCSR record, when the contractor does not submit entire claims for audit, or when the documentation submitted is illegible or incomplete rendering it in auditable. In these situations, occurrence errors are assessed for the error condition(s) attributable to the HCSR as a whole rather than to specific data fields. The following pertains to determining errors for these special conditions which are not associated with a particular data field.

a. "J" Category Error Conditions and Number of Errors Assessed

AUDIT CODE	RECORD	ERROR LOC	DESCRIPTION
01J	N	Detail	UNLIKE PROCEDURE COMBINED *7 errors for each erroneous utilization data set.
02J	I	Detail	UNLIKE REVENUE CODES COMBINED **5 errors for each erroneous revenue code set
03J	I – N	Detail	SERVICES SHOULD BE COMBINED 1 error for each additional revenue code/ utilization data set
04J	N	Common	MISSING NON-INSTITUTIONAL DATA SET *7 errors for each missing utilization data set
05J	N	Detail	EXTRA NON-INSTITUTIONAL UTILIZATION DATA SET *7 errors for each extra utilization data set
06J	I	Common	MISSING INSTITUTIONAL REVENUE CODE SET **5 errors for each missing revenue code set
07J	I	Detail	EXTRA INSTITUTIONAL REVENUE CODE SET **5 errors for each extra revenue code set
08J	I – N	Common	INCORRECT RECORD TYPE 5 errors
09J	I – N	Detail	SEPARATE HCSRs REQUIRED 3 errors
10J	I – N	Common	CLAIM NOT PROVIDED FOR AUDIT 1 error plus 1 error for each revenue code/ utilization data set in the HCSR
11J	I – N	Common	CLAIM NOT AUDITABLE 1 error plus 1 error for each revenue code/ utilization data set in the HCSR

CLAIMS AUDIT GUIDELINES

AUDIT CODE	RECORD	ERROR LOC	DESCRIPTION
12J	I – N	Common	UNSUPPORTED HCSR TRANSACTION 1 error plus 1 error for each revenue code/ utilization data set in the HCSR

* Not to exceed 21 errors for combination of OIJ, 04J and 05J error types.

** Not to exceed 15 errors for combination of 02J, 06J and 07J error types.

N = Non-Institutional HCSR

I = Institutional HCSR

Detail error location means the error pertains to a specific revenue code or utilization data set in the HCSR.

Common error location means the error pertains to the HCSR as a whole and not to any specific revenue code or utilization data set in the HCSR.

b. Auditing "J" Category Errors

01J UNLIKE SERVICES COMBINED (Non-institutional) MCSC Operations Manual, Chapter 8. Section 8.3.0. states that combining charges for the same procedures having the same billed charges under the contractor's "at-risk" operation, for health care service records, is optional if the same action is taken with all. When unlike services are combined, the auditor will assess an 0lJ error for each utilization data occurrence set within the HCSR containing incorrectly combined services up to a maximum of three OlJ errors per claim (or any combination of 01J, 04J and 05J). No other occurrence errors will be assessed against a line item for which the 0lJ error was charged.

The automated HCSR audit system will assess seven occurrence errors for each 0lJ error up to a maximum of 21 errors or an aggregate total of three (3) 01J, 04J or 05J errors for a maximum of 21 errors per claim.

02J UNLIKE REVENUE CODES COMBINED (Institutional). ADP Manual, Chapter 5, Section 6, Locator 1-365 provides for summarizing like revenue codes on the HCSR. Room and board revenue codes can be summarized if the code and rate are the same. Denied revenue codes must be reported on separate occurrence(s) within the HCSR. The auditor will assess an 02J error for each revenue data occurrence set within the HCSR containing incorrectly summarized revenue codes up to a maximum of three 0lJ errors per claim (not to exceed 15 errors for combination of 02J, 06J and 07J error types). No other occurrence errors will be assessed against a line item for which the 02J error was charged. The automated HCSR audit system will assess five occurrence errors for each 02J error up to a maximum of 15 errors or an aggregate total of three (3) 02J, 06J or 07J errors for a maximum of 15 errors per claim.

03J SERVICES SHOULD BE COMBINED (Institutional and Non-Institutional). This 03J error condition is the opposite of OlJ (Unlike Services Combined) described above except that only one error is assessed for each additional

revenue data occurrence set or utilization data occurrence set within the HCSR. This error also applies when the contractor "splits" a single service into more than one line item, e.g., a single charge for monthly rental of Durable Medical Equipment. All data fields on the revenue data occurrence set or utilization data occurrence set within the HCSR with this error condition should be audited for other error conditions.

04J MISSING NON-INSTITUTIONAL UTILIZATION DATA SET. Certain formatting errors result in utilization data occurrence sets not being reported on the HCSR record as they would have been if the transaction was correctly coded by the contractor. For example, when a utilization data occurrence sets is not reported because the contractor failed to process all the billings with the claim. When missing line items are identified, the auditor will assess an 04J error for each missing utilization data occurrence set within the HCSR up to a maximum of three errors per claim.

The automated HCSR audit system will assess seven occurrence errors for each 04J error up to a maximum of 21 errors or an aggregate total of three 01J, 04J or 05J errors for a maximum of 21 errors per claim.

05J EXTRA NON-INSTITUTIONAL UTILIZATION DATA SET. Extra records may occur on the HCSR record due to various reasons. One common example is when a utilization data occurrence set is coded for services not being claimed. When extra line items are present, the auditor will assess an 05J error for each extra utilization data occurrence set within the HCSR up to a maximum of three 05J errors per claim.

The automated HCSR audit system will assess seven occurrence errors for each 05J error up to a maximum of 21 errors or an aggregate total of three 01J, 04J or 05J errors for a maximum of 21 errors per claim.

06J MISSING INSTITUTIONAL REVENUE CODE SET. Certain formatting errors result in revenue data occurrence sets not being reported on the HCSR record as they would have if the transaction was correctly coded by the contractor. For example, when a revenue data occurrence set is not reported because the contractor failed to process all the billings with the claim. When missing line items are identified, the auditor will assess an 06J error for each missing revenue data occurrence set within the HCSR up to a maximum of three errors per claim.

The automated HCSR audit system will assess five occurrence errors for each 06J error up to a maximum of 15 errors or an aggregate total of three 02J. 04J or 06J errors for a maximum of 15 errors per claim.

07J EXTRA INSTITUTIONAL REVENUE CODE SET. Extra records may occur on the HCSR due to various reasons. One common example is when a revenue data occurrence set is coded for services not being claimed. When extra line items are present, the auditor will assess an 07J error for each extra revenue data occurrence set within the HCSR up to a maximum of three 07J errors per claim.

The automated HCSR audit system will assess five occurrence errors for each 07J error up to a maximum of 15 errors or an aggregate total of three 02J, 04J or 07J errors for a maximum of 15 errors per claim.

CLAIMS AUDIT GUIDELINES

08J INCORRECT RECORD TYPE (Institutional and Non-Institutional). Record type code 1 is to be used for institutional claims and record type code 2 is to be used for non-institutional claims. When other than the above two codes are used or when the record type on the HCSR is coded incorrectly for the services rendered an 08J error is assessed. The automated HCSR audit system will assess five errors for each record type assessed an 08J error.

09J SEPARATE HCSRs REQUIRED (Institutional and Non-Institutional). The ADP Manual, Chapter 1, Section 3. 1.0 and 2.0 requires that the HCSR consist of either an institutional or non-institutional record and lists the type of treatment encounter data that must be reported on separate HCSRS. If treatment encounter data does not meet the conditions listed in the ADP Manual an 09J error is assessed. The automated HCSR audit system will assess three errors when a separate HCSR is required.

10J CLAIM NOT PROVIDED FOR AUDIT(Institutional and Non-institutional). One
10J error is to be assessed for each claim selected for the audit sample, but not provided by the contractor. When a 10J error is assessed the automated HCSR audit system will assess one error plus one additional error for each revenue data occurrence set or utilization data occurrence set on the HCSR record. No other occurrence errors will be assessed.

1IJ CLAIM NOT AUDITABLE (Institutional and Non-institutional). One 11J error is to be assessed for in auditable claims that result from illegible copies of claims or attendant documentation, e.g., itemized bills, which are critical for the claim to be properly audited. When an 11J error is assessed the automated HCSR audit system will assess one error plus one additional error for each revenue data occurrence set or utilization data occurrence set on the HCSR record.. No other occurrence errors will be assessed.

12J UNSUPPORTED HCSR TRANSACTION (Institutional and Non-institutional.). One 12J error for unsupported HCSR record is to be assessed only when documentation submitted by the contractor for the audit does not indicate (does not support) that a claim against the government exists or that a HCSR record is required. Examples are a HCSR created solely for the contractor's internal accounting purposes and an "adjustment" processed when no determination or an incorrect determination has been made by the contractor that the HCSR as originally submitted requires correction. Only one 12J error is to be assessed per claim. When a 12J error is assessed the automated HCSR audit system will assess one error plus one additional error for each revenue data occurrence set or utilization data occurrence set on the HCSR record. No other occurrence errors are to be charged on a record when a 12J error is charged.

Claims denied for one reason which subsequently is resolved, e.g., ineligibility or requested information not received, is to be reprocessed with a new claim number and may be denied again for another reason. These situations are legitimate transactions and are not to be considered as 12J errors.

C. Payment Errors: The following types of payment errors and the codes for each are in effect for the contractors processing under the HCSR system. All apply to both Institutional and Non-institutional claims.

CLAIMS AUDIT GUIDELINES

(1) There are two categories of payment errors: (1) a payment error which cannot be removed by contractor post payment processing actions and (2) a payment error which can be removed by contractor post payment processing actions. Payment errors which can be removed by contractor post payment actions will also be assessed a process error at audit. If contractor post payment actions substantiate the initial processing decision, the payment error will be removed but the process error will remain. If the initial processing action is not substantiated, both the payment and the process error will remain. Claims containing process errors will not affect contractor payment or occurrence error rates, but will be used as a performance indicator.

(2) Payment errors are the amount of over/under payment on a claim, including but not limited to a payment in the correct amount but sent to the wrong payee, denial of a payable claim, misapplication of the deductible, payment of a noncovered service/supplies, or services/supplies for which a benefit determination cannot be made based on the information available at the time of processing. Process errors result from: noncompliance with a required procedure or process, such as development required but not performed, medical emergency not substantiated, medical necessity/review not evident and are cited in conjunction with a payment error. Process error determinations are based on the claim information available and those processing actions taken at the time of adjudication by the contractor.

(3) Payment errors which may not be removed by contractor post payment actions are based only on the claim information available and those processing actions taken at the time of adjudication by the contractor. Actions and determinations occurring subsequent to the processed date of the audited claim, are not a consideration of the audit for paid claims regardless of whether resolution of a payment error results. Subsequent reprocessing of a denied claim is considered as long as the processed to completion date of the reprocessed claim is prior to the run date of the audit sample.

(4) Types of Payment Errors: The following errors may be assessed. (An * indicates those payment errors which can be removed if contractor post payment actions substantiate the initial processing decision.)

*01K AUTHORIZATION/PREAUTHORIZATION NEEDED is assessed when the contractor paid a claim for which no authorization form is submitted when required. (Payment error may be removed by post payment actions only if PFPWD or adjunctive dental authorizations.)

*02K BENEFIT DETERMINATION UNSUPPORTED is assessed when the payment was made for services or supplies which require additional documentation to consider them as TRICARE benefits.

*03K BILLED AMOUNT INCORRECT is assessed when the contractor based payment on a billed amount other than what was being claimed.

04K COST-SHARE/DEDUCTIBLE ERROR is assessed when the contractor incorrectly calculated either of these amounts for reasons not covered in any

of the other "K" category errors, e.g., when the retiree cost-share is applied for services provided a dependent of an active duty sponsor.

*05K DEVELOPMENT CLAIM DENIED PREMATURELY is assessed when a claim is denied before the time period specified in the MCSC Operations Manual for development claims after the contractor has requested additional information in writing.

*06K DEVELOPMENT REQUIRED is assessed when the contractor processed the claim without taking action to obtain additional or correct information needed to correctly adjudicate the claim when such action is required by the MCSC Operations Manual.

07K DUPLICATE SERVICES PAID is assessed when the beneficiary history indicates that some or all of the services on the audited claim were paid previously, or when services are denied for duplicate by the contractor but the duplicate service is not found in the patient history.

08K ELIGIBILITY DETERMINATION PATIENT is assessed when the claim was paid or denied based on an incorrect eligibility determination for the patient.

09K ELIGIBILITY DETERMINATION PROVIDER is assessed when the claim was paid or denied based on an incorrect determination of the provider's authorization status for providing care under TRICARE.

*10K MEDICAL EMERGENCY NOT SUBSTANTIATED is assessed when a claim was paid as an emergency (Type of Admission = 1) and the claim does not qualify to be paid as such based on the TRICARE Reimbursements Manual requirements, i.e., the diagnosis is not among those which "automatically" qualify as medical emergencies, no medical review is evident, and a Nonavailability Statement or authorization is required.

*11K MEDICAL NECESSITY NOT EVIDENT is assessed when a claim was paid without documentation of medical review when medical review is required or when documentation of medical necessity is required and not provided with the claim.

12K NONAVAILABILITY STATEMENT ERROR is assessed when payment is made for non-emergency inpatient care provided a beneficiary residing within a Military Treatment Facility's catchment area for which no Nonavailability Statement or an invalid Nonavailability Statement is submitted.

13K OHI/TPL - GOVT PAY MISCALCULATED is assessed when the contractor incorrectly determines the amount of the TRICARE payment after applying the amount of the other insurance payment.

14K OHI/TPL PAYMENT ERROR is assessed when the claim contains documentation of other health insurance payment and the contractor fails to consider this in determining the TRICARE liability.

15K PAYEE WRONG - SPONSOR/PATIENT is assessed when payment is made to the incorrect sponsor or patient.

CLAIMS AUDIT GUIDELINES

16K PAYEE WRONG - PROVIDER is assessed when payment on participating claim was made to an incorrect provider.

17K PARTICIPATING/NONPARTICIPATING ERROR is assessed when a claim was paid to the provider who did not indicate participation on the claim or, conversely, to a patient or sponsor when the provider indicated participation.

18K PRICING INCORRECT is assessed when the amount allowed for a correct procedure code was incorrectly determined for any service or supply on the claim and results in an incorrect reimbursement.

19K PROCEDURE CODE INCORRECT is assessed when use of an incorrect procedure code resulted in incorrect reimbursement.

20K SIGNATURE ERROR is assessed when payment was made on a claim which does not contain the appropriate beneficiary or provider signature or does not contain beneficiary signature.

*21K TIMELY FILING ERROR is assessed when benefits for dates of service not meeting the timely filing requirement were paid without an appropriate waiver of the filing deadline, or when benefits were denied for not meeting the filing deadline when submission was timely.

22K DRG REIMBURSEMENT ERROR is assessed when an error was made by contractor in determining the reimbursement due an institution based on the DRG payment system.

23K CONTRACT JURISDICTION ERROR is assessed when benefits were paid for services or supplies rendered out of jurisdiction.

24K BENEFIT DETERMINATION WRONG is assessed when the payment was made for services or supplies which are not TRICARE benefits.

25K CLAIM NOT PROVIDED is assessed when the claim is selected for audit and not provided by the contractor.

26K CLAIM NOT AUDITABLE is assessed for in auditable claims that result from illegible copies of claims or attendant documentation which are critical for the claim to be properly audited.

27K INCORRECT AT RISK SYSTEM is assessed when HCSR was processed under the incorrect at risk system. An error exists when the provider affiliation code shows a provider paid as a network contractor or subcontractor when the provider was not under contract or vice versa. An error also exists when the enrollment status shows a beneficiary as enrolled in TRICARE Prime and contractor paid the claim as non-enrollee or vice versa.

*99K OTHER - SEE REMARKS is assessed when a payment error is detected and none of the above reasons apply. The auditor is to specify the reason for the payment error assessment in the free-form comments section of the screen when entering the audit errors in the automated HCSR Audit System.

CLAIMS AUDIT GUIDELINES

5. Assessing Payment Errors The HCSR audit system calculates both positive and negative payment error amounts. Therefore, when the contractor makes an overpayment on a claim that error is entered as a positive dollar amount and when the contractor makes an underpayment on a claim that error is entered as a negative dollar amount. The following rules apply when assessing payment errors:

a. Multiple payment error reasons which are different will be coded with the appropriate "K" error reason for a single HCSR.

b. In some cases, more than one payment error reason can apply, e.g., payment of a participating claim as nonparticipating and payment without an NAS. These are two mutually exclusive reasons, i.e., neither is dependent on the other. If only one of these conditions existed, the payment error would still exist. Each error is counted in these situations.

c. Auditors must ensure that only mutually exclusive reasons are assessed when determining that more than one reason applies. It is possible that more than one reason will appear to be appropriate when, in fact, they are related, e.g., incorrect procedure and incorrect pricing when the incorrect pricing is actually a result of the contractors use of an incorrect procedure.

6. Amount Billed for Computation of Payment Error Rates The HCSR audit system will display the amount allowed on DRG claims in the amount billed field and this field does not need to be changed except when the DRG amount allowed was incorrectly calculated by the contractor. The total amount billed will be computed by the HCSR Audit System as the total of the billed amounts on the HCSR Audit Detail Reports for a particular audit.

D. Procedural/Documentation Errors These errors listed on the HCSR Audit Detail Report as category "L" errors are neither occurrence errors nor payment errors and are not used to calculate the occurrence error or payment error rates. "L" errors are used to document the contractor's procedural errors and documentation problems which impact the audit process or indicate a situation of contractual noncompliance which is identifiable during the audit and requires follow-up corrective action by the appropriate Contracting Officer's Representative.

0Ll AUDIT DOCUMENTATION INCOMPLETE is assessed when certain documentation contractually required for the audit is not initially submitted with the claim for audit. This error differs from the 10J error, "Claim Not Provided", and the 11J error, "Claim Not Auditable," in that it does not prevent the auditor from completing the audit of the particular claim.

02L AUDIT DOCUMENTATION ILLEGIBLE is assessed when the contractor submits poor copies of claims or claim documentation, the legibility of which is difficult but does not impede the audit. This error differs from the 11J error, "Claim Not Auditable," in that auditing of the claim can be completed.

03L DOCUMENTATION SUBMITTED LATE is assessed when the contractor submits required claim documentation after completion of the audit, e.g., with the rebuttal.

CLAIMS AUDIT GUIDELINES

04L EOB INCORRECT is assessed when information on the Explanation of Benefits does not meet the MCSC Operations Manual requirements, e.g. EOBs addressed to minors or deceased individuals or EOBs containing incorrect denial messages.

05L NAS QUESTIONABLE is assessed when the contractor processed a claim based on an incorrectly completed or apparently invalid Nonavailability Statement without verifying its validity but which did not contribute to a payment error.

06L ERROR IN CLAIM HISTORY is assessed when the beneficiary claims history contains incorrect data, regardless of whether it pertains to the claim being audited.

07L RESERVED

08L ERRONEOUS CLAIM SPLIT is assessed when the contractor does not follow the Operations Manual limitations for creating more than one claim out of a single claim. When the contractor fails to process all services submitted on the claim being audited, the auditor is to check the beneficiary history to determine if the contractor processed these services as another claim and determine if this split is authorized by the MCSC Operations Manual.

09L ERRONEOUS HCSR SPLIT is assessed when the treatment encounter data on the HCSR is not reported in accordance with the instructions in the ADP Manual.

10L ADJUSTMENT - NO AUTHORIZING OFFICIAL is assessed when the contractor documentation supporting an adjustment does not contain the name of the authorizing person as required by its contract.

11L CONTRACT JURISDICTION ERROR is assessed when the contractor processed a claim out of their jurisdiction.

E. Process Errors: These errors are assessed for noncompliance of a required procedure/process. These errors are neither occurrence errors or payment errors and are not used to calculate the occurrence error or payment error rate.

01P Authorization/Pre-authorization Needed (PFPWD and adjunctive dental authorizations)

02P Unsupported Benefit Determinations

05P Development Claim Denied Prematurely

06P Development Required

10P Medical Emergency Not Substantiated

11P Medical Necessity/Review Not Evident

21P Timely Filing Error

CLAIMS AUDIT GUIDELINES

23P Contract Jurisdiction Error

99P Other

CLAIMS AUDIT GUIDELINES

EXHIBIT 1

HCSR AUDIT ERROR CATEGORIES

AUDIT CODE	HADR ABBREVIATION	DATA FIELD NAME
A CLAIM INFORMATION		
01A	FIL DT	Filing Date
02A	FIL ST	Filing State/Country
03A	SEQ NO	Sequence Number
04A	SUFFIX	HCSR Suffix
05A	PRG IND	Program Indicator
06A	SUBMISN	Type Of Submission
07A	RSN ADJ	Reason For Adjustment
08A	ADJ ID	Date Adjustment Identified
09A	PTC DT	Date HCSR Processed To Completion
10A	PLAN CODE	Health Care Plan Code
11A	SP PROC CD	Special Processing Code
12A	SP RATE CD	Special Rate Code
13A	NAS EXCEP	NAS Exception Reason
14A	NAS #	Nonavailability Statement Number
15A	OVERRIDE	Override Code
16A	DIAG EDTN	Diagnosis Edition Identifier
17A	PROC TEXT	Procedure Text Identifier
18A	GROUP ED	DRG Grouper Revision
19A	PRICER ID	DRG Pricer Revision
20A	OCCURRENCE COUNT	Occurrence Count
21A	REC TYPE	Record Type

CLAIMS AUDIT GUIDELINES

AUDIT CODE	HADR ABBREVIATION	DATA FIELD NAME
23A	MAJ DIAG CD	Major Diagnosis Code
24A	NAS ISS RSN CD	NAS Issue Reason Code
25A	CLM FORM TYP	Claim Form Type
26A	RSN PMT PEN	Reason For Payment Reduction
27A	RDCTN DAY/SER	Number Of Payment Reduction Days/Services
B. PATIENT/SPONSOR INFORMATION		
01B	PT NAME	Patient Name
02B	PT SSN	Patient SSN
03B	PT DOB	Patient Date Of Birth
04B	DEERS ID	DEERS Dependent Suffix
05B	PT SEX	Patient Sex
06B	PT ZIP	Patient Zip Code
07B	SP SSN	Sponsor Social Security Number
08B	SP PAY	Sponsor Pay Grade
09B	SP BOS	Sponsor Branch Of Service
10B	SP STAT	Sponsor Status
11B	PT RELAT	Patient Relationship To Sponsor
12B	ENRL STAT	Enrollment Status
C. PROVIDER INFORMATION		
01C	TAX ID	Provider Taxpayer Number
02C	SUB ID	Provider Sub-Identifier
03C	AFFIL	Provider Contract Affiliation

CLAIMS AUDIT GUIDELINES

AUDIT CODE	HADR ABBREVIATION	DATA FIELD NAME
04C	ST/CNTRY	Provider State Or Country Code
05C	ZIP	Provider Zip Code
06C	INST	Type Of Institution
07C	MAJ SPEC	Provider Major Specialty
08C	PART ID	Provider Participation Indicator
09C	CHAMPUS LOCALITY CODE	Provider CHAMPUS Locality Code
10C	MTF	MTF Code
D. ADMISSION/DISCHARGE INFORMATION		
01D	ADM DATE	Admission Date
02D	ADM TYPE	Type Of Admission
03D	ADM SOURCE	Source Of Admission
04D	DISCH STAT	Discharge Status
05D	BGN DOC	Begin Date Of Care
06D	END DOC	End Date Of Care
07D	FREQ	Frequency Code
08D	CLASS	Bill Classification Code
09D	BED DAYS	Total Bed Days
10D	AUTH DAYS	Government Authorized Bed Days
11D	BIRTHS	Number Of Births
E. INSTITUTIONAL DIAGNOSIS/TREATMENT INFORMATION		
01E	ADM DX	Admission Diagnosis
02E	PRN DX	Principal Treatment Diagnosis

CLAIMS AUDIT GUIDELINES

AUDIT CODE	HADR ABBREVIATION	DATA FIELD NAME
03E	SEC DX-1	Secondary Treatment Diagnosis-1
04E	SEC DX-2	Secondary Treatment Diagnosis-2
05E	SEC DX-3	Secondary Treatment Diagnosis-3
06E	SEC DX-4	Secondary Treatment Diagnosis-4
11E	SEC DX-5	Secondary Treatment Diagnosis-5
12E	SEC DX-6	Secondary Treatment Diagnosis-6
13E	SEC DX-7	Secondary Treatment Diagnosis-7
14E	SEC DX-8	Secondary Treatment Diagnosis-8
07E	PRN OP PROC	Principal Operation/Nonsurgical Procedure Code
08E	SEC PROC-1	Secondary Operation/Nonsurgical Procedure Code-1
09E	SEC PROC-2	Secondary Operation/Nonsurgical Procedure Code-2
15E	SEC PROC-3	Secondary Operation/Nonsurgical Procedure Code-3
16E	SEC PROC-4	Secondary Operation/Nonsurgical Procedure Code-4
17E	SEC PROC-5	Secondary Operation/Nonsurgical Procedure Code-5
10E	DRG NUMBER	DRG Number
F. NONINSTITUTIONAL DIAGNOSIS INFORMATION		
01F	PRIN DX	Principal Treatment Diagnosis
02F	SEC DX-1	Secondary Treatment Diagnosis-1
03F	SEC DX-2	Secondary Treatment Diagnosis-2
04F	SEC DX-3	Secondary Treatment Diagnosis-3
05F	SEC DX-4	Secondary Treatment Diagnosis-4
G. FINANCIAL INFORMATION		

CLAIMS AUDIT GUIDELINES

AUDIT CODE	HADR ABBREVIATION	DATA FIELD NAME
01G	AMT BILL	Amount Billed
02G	AMT ALLOW	Amount Allowed
03G	AMT OHI	Amount Of Other Health Insurance
04G	TPL	Amount Of Third Party Liability
05G	PT COINS	Patient Coinsurance
06G	APPL DED	Amount Applied Toward Deductible
07G	PT COPAY	Patient Copayment
08G	AMT PAID	Amount Paid By Government Contractor
09G	AMT PEN	Amount Of Payment Reduction
10G	ALWD OHI	Amount Allowed By Other Health Insurance
H. INSTITUTIONAL REVENUE DATA		
01H	REVENUE CODE	Revenue Code
02H	UNITS OF SERVICE	Units Of Service By Revenue Code
03H	TOTAL CHARGE	Total Charge By Revenue Code
04H	DENIAL CODE	Denial Reason Code
05H	LN	Occurrence Counter
I. NON-INSTITUTIONAL UTILIZATION DATA		
01I	PROC CODE	Procedure Code
02I	NBR SERV	Number Of Services
03I	TOTAL CHRGS	Total Charges By Procedure Code
04I	AMOUNT ALLOWD	Amount Allowed By Procedure Code
05I	PRICE CODE	Pricing Code

CLAIMS AUDIT GUIDELINES

AUDIT CODE	HADR ABBREVIATION	DATA FIELD NAME
06I	BGN DT CARE	Begin Date Of Care
07I	END DT CARE	End Date Of Care
08I	PLA SRV	Place Of Service
09I	TYPE SRV	Type Of Service
10I	DENIAL REASON	Denial Reason Code
11I	LN	Occurrence Counter
12I	PRICE PROF	Pricing Profile
13I	CPT-4 MOD	CPT-4 Modifer

J. INCORRECT/UNSUPPORTED RECORD ERRORS (No specific data field applies to these codes.)

01J Unlike Procedures Combined

02J Unlike Revenue Codes Combined

03J Services Should Be Combined

04J Missing Non-institutional Utilization Data Set

05J Extra Non-institutional Utilization Data Set

06J Missing Institutional Revenue Code Set

07J Extra Institutional Revenue Code Set

08J Incorrect Record Type

09J Separate HCSR'S Required

10J Claim Not Provided For Audit

11J Claim Not Auditable

12J Unsupported HCSR Transaction

K. INCORRECT PAYMENT ERRORS (No specific data field applies to these codes.)

01K Authorization/Preauthorization Needed

02K Benefit Determination Unsupported

CLAIMS AUDIT GUIDELINES

03K Billed Amount Incorrect

04K Cost-Share/Deductible Error

05K Development claim denied prematurely

06K Development Required

07K Duplicate Services Paid

08K Eligibility Determination - Patient

09K Eligibility Determination - Provider

10K Medical Emergency Not Substantiated

11K Medical Necessity Not Evident

12K Nonavailability Statement Error

13K OHI/TPL - Government Pay Miscalculated

14K OHI/TPL Payment Omitted

15K Payee Wrong - Sponsor/Patient

16K Payee Wrong - Provider

17K Participating/Nonparticipating Error

18K Pricing Incorrect

19K Procedure Code Incorrect

20K Signature Error

21K Timely Filing Error

22K DRG Reimbursement Error

23K Contract Jurisdiction Error

24K Benefit Determination Wrong

25K Claim Not Provided

26K Claim Not Auditable

27K Incorrect At Risk System

99K Other - See Remarks

L. DOCUMENTATION/INCORRECT PROCEDURE ERRORS (No specific data field applies to these codes.

01L Audit Documentation Incomplete

CLAIMS AUDIT GUIDELINES

02L Audit Documentation Illegible

03L Documentation Submitted Late

04L EOB Incorrect

05L NAS Questionable

06L Error In Claim History

07L Reserved

08L Erroneous Claim Split

09L Erroneous HCSR Split

10L Adjustment - No Authorizing Official

11L Contract Jurisdiction Error

M. PROCESS ERRORS

01P Authorization/Pre-Authorization Needed (PFPWD and Adjunctive Dental Authorizations)

02P Unsupported Benefit Determination

05P Development Claim Denied Prematurely

06P Development Required

10P Medical Emergency Not Substantiated

11P Medical Necessity/Review Not Evident

21P Timely Filing Error

23P Contract Jurisdiction Error

99P OTHER